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Female Health & Wellness Follow Up Visit

Name: ____ Date:_________________________

Have your symptoms improved, deteriorated or remained the same since your last visit?(check below)
If your symptoms have changed since your last visit, please explain:______________________
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Please check the boxes below completely:	***None***	***Mild***	***Mod***	***Severe***
Increase of breast size				
Impatient, snappy behavior				
Pelvic cramps				
Nausea				
Flabbiness and muscular weakness				
Loss of hair				
Lack of energy and stamina				
Loss of coordination and balance				
Decreased sex drive				
Decreased hair (armpit,pubic,body)				
Harder to reach climax				
Pain with sexual activity				
Decreased muscle strength				
Fibromyalgia				
Water Retention				
Forgetfulness				
Depression				

Please check the boxes below completely:	*None*	*Mild*	*Mod*	*Severe*
Minor anxiety				
Mood changes				
Difficulty Falling asleep				
Hot flashes				
Temperature swings				
Day long fatigue				
Decreased sense of sexuality				
Lessened self-image				
Dry eyes, skin, vagina				
Sagging breast and loss of fullness				
Weight gain				
Joint/body aches and pain				
Mental fogginess				

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Please sign your name