Hormone Related Symptoms

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME DATE

Read the list below and check the box marked Y *if the statement applies to you. Check the box marked* N *if it does not apply to you.*

Y ☐ N ☐ I have to struggle to finish jobs
Y ☐ N ☐ I feel a strong need to sleep during the day
Y ☐ N ☐ I often feel lonely even when I am with other people
Y ☐ N ☐ I have to read things several times before they sink in
Y ☐ N ☐ It is difficult for me to make friends
Y ☐ N ☐ It takes a lot of effort for me to do simple tasks
Y ☐ N ☐ I have difficulty controlling my emotions
Y ☐ N ☐ I often lose track of what I want to say
Y ☐ N ☐ I lack confidence
Y ☐ N ☐ I have to push myself to do things
Y ☐ N ☐ I often feel very tense
Y ☐ N ☐ I feel as if I let people down
Y ☐ N ☐ I find it hard to mix with people
Y ☐ N ☐ I feel worn out even when I've not done anything
Y ☐ N ☐ There are times when I feel very low
Y ☐ N ☐ I avoid responsibilities if possible
Y ☐ N ☐ I avoid mixing with people I don't know well
Y ☐ N ☐ I feel as if I'm a burden to people
Y ☐ N ☐ I often forget what people have said to me
Y ☐ N ☐ I find it difficult to plan ahead
Y ☐ N ☐ I am easily irritated by other people
Y ☐ N ☐ I often feel too tired to do the things I ought to do
Y ☐ N ☐ I have to force myself to do all the things that need doing
Y ☐ N ☐ I often have to force myself to stay awake
Y ☐ N ☐ My memory lets me down

[Doctor's use only: Score: 11]

Y ☐ N ☐ Have you ever been knocked unconscious? Details:
Y ☐ N ☐ Have you ever had a concussion? Details:
Y ☐ N ☐ Been in a coma? Details:
Y ☐ N ☐ Been in a car accident? Details:
Y ☐ N ☐ Had whiplash? Details:
Y ☐ N ☐ Played sports? Details:

Signs and Symptoms

	NEVER	SOMETIMES	REGULARLY	OFTEN	CONSTANTLY
1. I look older than I am	☐	☐	☐	☐	☐
2. I have trouble falling asleep at night	☐	☐	☐	☐	☐
3. I wake up during the night	☐	☐	☐	☐	☐
4. And I can't get back to sleep	☐	☐	☐	☐	☐
5. My mind is busy with anxious thought while I am trying to fall asleep	☐	☐	☐	☐	☐
6. My feet are too hot at night	☐	☐	☐	☐	☐
7. When I get up, I don't feel rested	☐	☐	☐	☐	☐
8. I feel like I'm living out of sync with the world, going to bed late and waking up late	☐	☐	☐	☐	☐
9. I can't tolerate jet lag	☐	☐	☐	☐	☐
10. I smoke, drink and/or use a sleep aid	☐	☐	☐	☐	☐

[Doctor's use only: Score: 10/20]

	NEVER	SOMETIMES	REGULARLY	OFTEN	CONSTANTLY
1. I'm sensitive to cold	☐	☐	☐	☐	☐
2. My hands and feet are always cold	☐	☐	☐	☐	☐
3. In the morning, my face is puffy and my eyelids are swollen	☐	☐	☐	☐	☐
4. I put on weight easily	☐	☐	☐	☐	☐
5. I have dry skin	☐	☐	☐	☐	☐
6. I have trouble getting up in the morning	☐	☐	☐	☐	☐
7. I feel more tired at rest than when I am active	☐	☐	☐	☐	☐
8. I am constipated	☐	☐	☐	☐	☐
9. My joints are stiff in the morning	☐	☐	☐	☐	☐

[Doctor's use only: Score: 10/20]