PATIENTS: PLEASE FILL OUT BOTH PAGES COMPLETELY AND RETURN TO THE LAB WITH YOUR SAMPLE(S)

PATIENT SURVEY

First Name | Middle Initial | Last Name | DOB (MM/DD/YY)

Symptoms: Please indicate the symptoms you are experiencing by filling in the boxes as follows: **0 = none, 1 = mild, 2 = moderate, 3 = severe**

Be sure to completely fill in the box with black or blue ink. Example: ■ Correct ▬ ☒ ◉ Incorrect

ALL INDIVIDUALS

0	1	2	3	
☐	☐	☐	☐	Difficulty Concentrating
☐	☐	☐	☐	Increased Forgetfulness
☐	☐	☐	☐	Foggy Thinking
☐	☐	☐	☐	Tearful
☐	☐	☐	☐	Depressed
☐	☐	☐	☐	Mood Swings
☐	☐	☐	☐	Fluid Retention/Bloating
☐	☐	☐	☐	Stress
☐	☐	☐	☐	Anxious
☐	☐	☐	☐	Irritable
☐	☐	☐	☐	Nervous
☐	☐	☐	☐	Decreased Mental Sharpness
☐	☐	☐	☐	Morning Fatigue
☐	☐	☐	☐	Afternoon Fatigue

0	1	2	3	
☐	☐	☐	☐	Evening Fatigue
☐	☐	☐	☐	Excessive Worry
☐	☐	☐	☐	Difficulty Falling Asleep
☐	☐	☐	☐	Difficulty Staying Asleep
☐	☐	☐	☐	Decreased Stamina
☐	☐	☐	☐	Diminished Motivation
☐	☐	☐	☐	Fibromyalgia
☐	☐	☐	☐	Ringing in Ears
☐	☐	☐	☐	Allergies
☐	☐	☐	☐	Headaches/Migraines
☐	☐	☐	☐	Dizzy Spells
☐	☐	☐	☐	Sugar Cravings
☐	☐	☐	☐	Craving Food, Alcohol, Tobacco, or Other

0	1	2	3	
☐	☐	☐	☐	Poor Impulse Control
☐	☐	☐	☐	Obsessive Behavior (OCD)
☐	☐	☐	☐	Addictive Behavior
☐	☐	☐	☐	Constipation
☐	☐	☐	☐	Goiter
☐	☐	☐	☐	Cold Body Temperature
☐	☐	☐	☐	Hoarseness
☐	☐	☐	☐	Hair Dry or Brittle
☐	☐	☐	☐	Nails Breaking or Brittle
☐	☐	☐	☐	Slow Pulse Rate
☐	☐	☐	☐	Rapid Heartbeat
☐	☐	☐	☐	Heart Fluttering/Palpitations
☐	☐	☐	☐	Incontinence
☐	☐	☐	☐	Hot Flashes

0	1	2	3	
☐	☐	☐	☐	Night Sweats
☐	☐	☐	☐	Infertility Concerns
☐	☐	☐	☐	Acne
☐	☐	☐	☐	Scalp Hair Loss
☐	☐	☐	☐	Weight Gain-Hips
☐	☐	☐	☐	Weight Gain-Waist
☐	☐	☐	☐	High Cholesterol
☐	☐	☐	☐	Elevated Triglycerides
☐	☐	☐	☐	Decreased Libido
☐	☐	☐	☐	Decreased Muscle Size
☐	☐	☐	☐	Decreased Flexibility
☐	☐	☐	☐	Burned Out Feeling
☐	☐	☐	☐	Sore Muscles
☐	☐	☐	☐	Increased Joint Pain

0	1	2	3	
☐	☐	☐	☐	Neck or Back Pain
☐	☐	☐	☐	Bone Loss
☐	☐	☐	☐	Thinning Skin
☐	☐	☐	☐	Rapid Aging
☐	☐	☐	☐	Aches and Pains
☐	☐	☐	☐	IBS

☐ Personal/family history of breast, uterine, or ovarian cancer

AMINO ACIDS OR OTHER MEDICATION USE

Indicate if you have taken any of the following in the stated time frame:

	Less than 12 hours	12-36 hours	36 hours-2 weeks
5-HTP	☐	☐	☐
GABA	☐	☐	☐
Glutamine	☐	☐	☐
Gycine	☐	☐	☐
Histidine	☐	☐	☐
Phenylalanine	☐	☐	☐
Phenethylamine (PEA)	☐	☐	☐
SAMe	☐	☐	☐
Theanine	☐	☐	☐
Tryptophan	☐	☐	☐
Tyrosine	☐	☐	☐
Epinephrine-containing meds	☐	☐	☐

WOMEN ONLY

0	1	2	3	
☐	☐	☐	☐	Vaginal Dryness
☐	☐	☐	☐	Irregular Periods
☐	☐	☐	☐	Uterine Fibroids
☐	☐	☐	☐	Tender Breasts
☐	☐	☐	☐	Fibrocystic Breasts
☐	☐	☐	☐	Increased Facial/Body Hair

MEN ONLY

0	1	2	3	
☐	☐	☐	☐	Decreased Urine Flow
☐	☐	☐	☐	Increased Urinary Urge
☐	☐	☐	☐	Prostate Problems
☐	☐	☐	☐	Decreased Erections

THIS SPACE FOR LAB USE ONLY

12/21

CONTINUE TO OTHER SIDE FOR HORMONE USE

Hormone Use: Please note all hormones (including hormonal birth control) you have used in the past 2 months, and note any hormone pellets you had inserted in the last 6 months. Fill in the boxes corresponding to current use. ***Be sure to completely fill in the box with black or blue ink.***

	Conjugated Estrogens (i.e. Premarin)	**Estradiol + Progestin** (i.e. birth control pills, HRT)	**Progestin only** (i.e. minipill, Depo injection, IUD)	**Estrone** (E1)	**Estradiol** (E2)	**Estriol** (E3)	**Progesterone** (P4)	**Testosterone** (T)	**DHEA**	**Corticosteroid** (i.e. cortisol, hydrocortisone, prednisone)	**Pregnenolone**	**Thyroid**	**Melatonin**
1. How is your hormone therapy administered?													
Topical Cream or Gel, or Vaginal Suppository	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Topical Patch	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Oral	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sublingual (dissolved under the tongue)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
IM (intra-muscular) or SQ (sub-cutaneous) Injection	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
SQ Pellet	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inhaler	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
IUD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. How long between last use and first sample collection? For IUD/pellets/injections, mark the box to indicate date of insertion/injection.													
Less than 12 hours	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12-24 hours	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25-36 hours	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
37-72 hours	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4-7 days	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8-14 days	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15-45 days	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1.5-4 months	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4-6 months	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6 months or more	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. What is your dosage regimen? (How often your hormone therapy is administered)													
Once a day	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Twice a day	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Once per week	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2-4 times per week	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Every 2 weeks	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Monthly	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Every 3 months	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Every 6 months	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Continuous (IUD only)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. TOPICAL hormones used by members of your household	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐