Female Hormone Treatment Form

Pt Name:_____

Level of Hormone Treatment satisfaction to date: *(not satisfied)* 0 1 2 3 4 5 6 7 8 9 10 *(very satisfied)*

1. Are you having any issues or problems with sleep, irritability, anxiety, or forgetfulness? (Yes) (No)

If **yes**, please explain:

_____

_____

2. Are you experiencing any problems with libido (sex drive), difficulty achieving orgasms, or loss of muscle tone? (Yes) (No)

If **yes**, please explain:

_____

_____

3. Have you had a Hysterectomy? (yes) (no) IF NO: Are you having any problems with periods in any way? (Yes) (No)

If **yes**, please explain:

_____

_____

4. Are you having any vaginal dryness, night sweats, or hot flashes? (Yes) (No)

If **yes**, please explain:

_____

_____

5. Are you experiencing any problems with motivation, mental focus, acne, anger, weight gain, or hair loss? (Yes) (No)

If **yes**, please explain:

_____

_____

Any other comments/concerns:

_____

_____

_____

BELOW FOR NURSING/PROVIDER USE

Last weight: _____lb Current weight: _____lb Height: _____in BP: _____ Pulse: _____ Temp: _____

Current regimen:

- ☐ Testosterone Cypionate 200mg/mL weekly IM DOSE: _____mL
- ☐ Estradiol Cypionate 10mg/mL weekly IM DOSE: _____mL
- ☐ Progesterone Oral capsules once a day at bedtime dose: _____mg
- ☐ PELLET THERAPY – last doses placed: TESTOSTERONE_____mg ESTRADIOL_____mg
- ☐ Vitamin B12 1000mcg/mL ____mL IM (weekly) (every 2 weeks) (every 4 weeks)
- ☐ _____
- ☐ _____

Notes/Plan:

_____

_____

_____

_____

_____

_____

New Regimen: Testosterone:_____mg Estradiol: _____mg Progesterone:_____mg qHS

Other changes:_____

_____

_____