Female HRT Questionnaire:

1.	Hot flashes or night sweats?	Yes	No
2.	Difficulty falling asleep or staying asleep?	Yes	No
3.	Decreased or absent libido?	Yes	No
4.	Weight gain?	Yes	No
5.	Fatigue despite getting a good night's rest?	Yes	No
6.	Decreased clarity of thoughts?	Yes	No
7.	Thinning of hair or hair loss?	Yes	No
8.	Any skin changes, or increased dryness to skin?	Yes	No
9.	Personal or family history of blood clots?	Yes	No
10.	Do you smoke?	Yes	No
11.	History of bone fractures?	Yes	No
12.	Cold extremities such as hands or feet?	Yes	No
13.	No energy to do the things you used to do?	Yes	No

14. Date of last mammogram:
15. Date of last pap:
16. Bone Density Scan: