CBJR WELLNESS

SYMPTOMS SHEET

Date: ________________________

Patient Name: ______________________________ DOB: _________________________

Smoker: ______(Y) _______(N) NEW ________F/U____________

Women:

_______Acne

_____Facial Hair

_____Hair Loss

_____Breast Tenderness

_____Pre-Menstrual Migraines

_____Weight Gain

BTB ___________ If yes resolved_____
FIBROCYSTIC BRST_____

Medical History:

_____ Hysterectomy

_____ History of breast CA

_____ Fibrocystic breast disease

_____ PCOS

_____ HX of Leiomyoma or Endometrial polyps

_____ Hashimoto's Thyroiditis
_____ On Birth Control

_____ Current HRT _________

Males:

Physical Activity Level

_____Low

_____Moderate

_____Medium High

_____High

Medical History:

_____ On 5a Reductase

_____ Work up Performed & OK

_____ Prostate CA

_____Hashimoto's Thyroiditis