HARPER
RESTORATION SYSTEM

SYMPTOM QUESTIONNAIRE

Please circle a number for each symptom ranging from 0, meaning NO symptom, to 10 meaning severe symptoms, to let us know how you are feeling today.

PROGESTERONE	LOW						MODERATE				SEVERE	COMMENTS, IF ANY
Sleep Disturbances	0	1	2	3	4	5	6	7	8	9	10	
Depression	0	1	2	3	4	5	6	7	8	9	10	
Irritability	0	1	2	3	4	5	6	7	8	9	10	
Anxiety	0	1	2	3	4	5	6	7	8	9	10	
Mood Swings	0	1	2	3	4	5	6	7	8	9	10	
Migraine Headaches	0	1	2	3	4	5	6	7	8	9	10	
Palpitations	0	1	2	3	4	5	6	7	8	9	10	

ESTROGEN	LOW						MODERATE				SEVERE	COMMENTS, IF ANY
Painful Intercourse	0	1	2	3	4	5	6	7	8	9	10	
Night Sweats	0	1	2	3	4	5	6	7	8	9	10	
Hot Flashes	0	1	2	3	4	5	6	7	8	9	10	
Dry Skin	0	1	2	3	4	5	6	7	8	9	10	
Chronic Fatigue	0	1	2	3	4	5	6	7	8	9	10	
Restless Leg Syndrome	0	1	2	3	4	5	6	7	8	9	10	
Hair Loss (Women)	0	1	2	3	4	5	6	7	8	9	10	

TESTOSTERONE	LOW						MODERATE				SEVERE	COMMENTS, IF ANY
Fatigue	0	1	2	3	4	5	6	7	8	9	10	
Weight Control	0	1	2	3	4	5	6	7	8	9	10	
Low Sex Drive	0	1	2	3	4	5	6	7	8	9	10	
Erectile Dysfunction	0	1	2	3	4	5	6	7	8	9	10	
Poor Focus	0	1	2	3	4	5	6	7	8	9	10	
Body Joint Pains	0	1	2	3	4	5	6	7	8	9	10	
Memory Lapses	0	1	2	3	4	5	6	7	8	9	10	
Low Exercise Tolerance	0	1	2	3	4	5	6	7	8	9	10	
Loss of Muscle Tone	0	1	2	3	4	5	6	7	8	9	10	

Patient Comments or any changes in Medical Condition or Medications since last report: _____

_____

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____