



NUW Hormone Assessment Expanded

Name: _____

Date: _____

1 = Mild, 2 = Moderate, 3 = Severe, BLANK = does not apply

Section 1 (E) _____ Score

- | | | |
|-------------------------------|---------------------------|-------------------------|
| ____ Hot flashes | ____ Decreased Sensuality | ____ Vertical lip lines |
| ____ Night sweats | ____ Painful Intercourse | ____ High cholesterol |
| ____ Depression | ____ Urinary leakage | ____ Back & joint pain |
| ____ Brain fog | ____ Droopy breasts | ____ Low bone density |
| ____ Fatigue/low energy | ____ Dry, dehydrated skin | ____ Breast tenderness* |
| ____ Weight gain | ____ Thinning skin | ____ Breast fullness* |
| ____ Vaginal dryness | ____ Loss of glow | ____ Nipple tenderness* |
| ____ Urinary tract infections | ____ Dry eyes | ____ Fluid retention* |

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Section 2 (P) _____ Score

- | | | |
|-------------------------------|-----------------------------|-----------------------------|
| ____ Poor sleep | ____ Breast lumps/cysts | ____ History of infertility |
| ____ Irritability | ____ Swollen feet/ankles | ____ History of miscarriage |
| ____ Anxious | ____ Period irregularities | ____ Headaches/migraines |
| ____ Mood swings | ____ Scanty menstruation | ____ Acne |
| ____ Unable to relax | ____ PMS | ____ Low bone density |
| ____ Swollen, painful breasts | ____ Fibroids/endometriosis | ____ Drowsiness* |

Continued...

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Section 3 (T) _____ Score

_____ Loss of muscle	_____ Dry eyes	_____ Unwanted hair growth*
_____ Abdominal weight gain	_____ Loss of confidence	_____ Voice changes*
_____ Cellulite	_____ Low energy/stamina	_____ Aggression*
_____ Varicose veins	_____ Digestive issues	_____ Oily skin*
_____ Low/no libido	_____ Poor tissue repair	_____ Thinning hair*
_____ Lack of orgasm	_____ Immune dysfunction	_____ Acne*
_____ Low clitoral sensitivity	_____ Low bone density	_____ Worse body odor*

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Section 4 (I) _____ Score

_____ Menstrual cycle longer than 28 days	_____ Excess body hair on face, arms, chest, back, or buttocks
_____ Cystic acne	_____ Infertility
_____ Weight-loss resistant	_____ Mid-cycle/ovulation pain
_____ Diagnosed PCOS	_____ "Hangry"

Section 5 (M) _____ Score

Do you still have your uterus? YES _____ NO _____

How many ovaries do you have? ZERO _____ ONE _____ BOTH _____

When was your last menstrual period? _____

Average length of time from one period to the next? _____

Describe flow and cramping:

Continued...

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Section 6 (CI) _____ Score

_____ Known or suspected breast cancer or other estrogen or progesterone-sensitive cancer

_____ Undiagnosed vaginal/genital bleeding

_____ Active or recent artery or vein thromboembolic disease (blood clots)

_____ Known or suspected pregnancy today

_____ Active, severe liver disease or dysfunction

_____ Known calcifications or hardening of the arteries

_____ Currently smoke or vape

If you answered YES to any item in Section 6, please provide details below.

Hormone replacement therapy is not without risk. Consult your medical provider before adding hormones to your wellness plan.

Signature: _____ Date: _____