

Be.....Balanced Progress Note

NAME _____

DATE _____

	<u>Same</u>	<u>Better</u>	<u>Worse</u>		<u>Same</u>	<u>Better</u>	<u>Worse</u>		<u>Same</u>	<u>Better</u>	<u>Worse</u>
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sex Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breasts tender	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Salt Craving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Erectile function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PMS symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Sugar cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oily skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Foggy thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Period	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

ENERGY LEVEL: 8 am _____ Noon _____ 4 pm _____ 8 pm _____

HOURS SLEEP/NIGHT: _____ **EXERCISE/WEEK:** _____

CURRENT STRESS LEVEL (1-10): _____

CURRENT TYPICAL DAILY DIET:

Fruits/Vegetables daily: _____ Breads/pastas daily: _____ Soda/coffee daily: _____

Meat/protein per day: _____ Sweets/Candy daily: _____ Organic? _____

NEW PROBLEMS AND CONCERNS:

SUPPLEMENTS YOU ARE TAKING:

HPI

PHYSICAL EXAMINATION

Age _____ Wt _____ BP _____ Pulse _____

HEENT: NORMAL _____

BREASTS: NORMAL _____

LUNGS: NORMAL _____

CV: NORMAL _____

ABDOMEN: NORMAL _____

GU: NORMAL _____

SKIN: NORMAL _____

LAB RESULTS REVIEWED DIAGNOSTIC TESTS REVIEWED SUPPLEMENTS REVIEWED/REVISED

SALIVA TEST REVIEWED FOOD DIARY REVIEWED

MEDICATIONS REVIEWED. CURRENT BHRT REGIMEN _____

MEDICAL SUMMARY:

Hormone Imbalance Hypothyroid Hypoadrenalism Vitamin deficiency Insulin Resistance

Adult GH Deficiency Menopause Osteoporosis Diminished Sex Drive Candida

Atrophic Vaginitis Mood disorder Intestinal Dysbiosis Hyperlipidemia Insomnia

Other: _____

PLAN:

Saliva kit 24 hour urine fasting labwork _____ One week food/drink diary to next visit

Continue current BHRT Educational information Counseling (30 min)

Adjust/Begin BHRT: _____ Supplements to follow up visit

Other: F/U appt _____ wks _____ mos

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Patient reminded of importance of dietary modification and gradual incorporation of increasing levels of exercise.

