

PATIENT CHECKLIST FOR SYMPTOMS OF HORMONE IMBALANCE

For Women

The following checklists can be used to help you and your healthcare provider determine specific symptoms of hormone imbalance.

Category 1: Basic Hormone Imbalance

Note which of the following symptoms are troublesome and/or persist over time.

<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Mood swings (PMS)	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Cystic ovaries	<input type="checkbox"/> Vaginal dryness	<input type="checkbox"/> Acne
<input type="checkbox"/> Heavy menses	<input type="checkbox"/> Foggy thinking	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Depressed mood
<input type="checkbox"/> Fibrocystic breasts	<input type="checkbox"/> Irritability	<input type="checkbox"/> Increased body/facial hair	<input type="checkbox"/> Headaches
<input type="checkbox"/> Thinning skin	<input type="checkbox"/> Uterine fibroids		<input type="checkbox"/> Bone loss

Number selected _____

Category 2: Adrenal Hormone Imbalance

Note which of the following symptoms are troublesome and/or persist over time.

<input type="checkbox"/> Aches and pains	<input type="checkbox"/> Elevated triglycerides	<input type="checkbox"/> Morning fatigue	<input type="checkbox"/> Bone loss
<input type="checkbox"/> Sleep disturbances	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Blood sugar imbalance
<input type="checkbox"/> Infertility	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Allergic conditions	<input type="checkbox"/> Autoimmune illness
<input type="checkbox"/> Chronic illness	<input type="checkbox"/> Evening fatigue	<input type="checkbox"/> Susceptibility to infections	

Number selected _____

Category 3: Thyroid Hormone Imbalance

Note which of the following symptoms are troublesome and/or persist over time.

<input type="checkbox"/> Aches and pains	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Brittle nails	<input type="checkbox"/> Depression
<input type="checkbox"/> Dry skin	<input type="checkbox"/> Cold hands and feet	<input type="checkbox"/> Headaches	<input type="checkbox"/> Infertility
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Foggy thinking	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Feeling cold all the time
<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Low libido	<input type="checkbox"/> Inability to lose weight	<input type="checkbox"/> Sleep disturbances
<input type="checkbox"/> Constipation	<input type="checkbox"/> Thinning hair	<input type="checkbox"/> Menstrual irregularities	<input type="checkbox"/> Elevated cholesterol

Number selected _____