



*Dr. Shel*  
WELLNESS & MEDICAL SPA

## Women's Questionnaire

Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Age: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Marital Status: M W D Sp S Occupation: \_\_\_\_\_

Date of Last Menstrual Period: \_\_\_\_\_ # of pregnancies \_\_\_\_\_ # of deliveries \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Please check all applicable and explain:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Excessive Weight         | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Mental Health/Depression |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Mitral Valve Prolapse    |
| <input type="checkbox"/> Colitis                  | <input type="checkbox"/> Hypertension          | <input type="checkbox"/> Multiple Sclerosis       |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Hypothyroidism        | <input type="checkbox"/> Chronic Yeast Infection  |
| <input type="checkbox"/> Elevated Cholesterol     | <input type="checkbox"/> Irrit. Bowel Syndrome | <input type="checkbox"/> Seizures                 |
| <input type="checkbox"/> Elevated Triglycerides   | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Sleep Disorders          |
| <input type="checkbox"/> Heart Disease            | <input type="checkbox"/> Stroke                | <input type="checkbox"/> Skin Complaints          |

Health Maintenance: (Date last done)

Bone Density: \_\_\_\_\_ MMG \_\_\_\_\_ Pap \_\_\_\_\_

Lipid Profile: \_\_\_\_\_ Flex Sigmoidoscopy \_\_\_\_\_

Medical Problems: (Explained from above) \_\_\_\_\_

\_\_\_\_\_

Name and number of Primary Care Physician \_\_\_\_\_

Current Medications/Supplements: \_\_\_\_\_

\_\_\_\_\_

Birth Control Method \_\_\_\_\_ Hormones \_\_\_\_\_

Do you have any drug allergies?  No  Yes If yes, give reaction medication and reaction \_\_\_\_\_

Do you exercise?  No  Yes What kind? \_\_\_\_\_ How Often \_\_\_\_\_

Do you smoke?  No  Yes How much? \_\_\_\_\_ How Long? \_\_\_\_\_

Do you use alcohol?  No  Yes How much? \_\_\_\_\_ How Long? \_\_\_\_\_

*P:\Patient Paperwork\Administrative\Consultation Forms\Women's Questionnaire*

Have you had a major illness/hospitalization/surgery?  No  Yes

Explain: \_\_\_\_\_

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Is there a family history of: (Please check)

- Colon Cancer       Ovarian Cancer       Diabetes       Breast Cancer  
 High Blood Pressure       Heart Disease       Other \_\_\_\_\_

Are you interested in our other services:

- Nutritional testing       Laser Rejuvenation       Cellulite Treatment  
 Weight Management       Skin Care       Mineral Makeup  
 Allergy Testing       Laser Skin Tightening       Facial Treatments  
 Massage/ PT       Laser Hair Removal       Laser Hair Regrowth

### Children

Name and age of children

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

### Family History

	Medical Problem(s)
Father- alive or deceased? Age _____	_____
Mother- alive or deceased? Age _____	_____
Brothers/sisters: _____	Medical Problem(s) _____
_____ Age _____	_____
_____ Age _____	_____
_____ Age _____	_____

## REVIEW OF SYMPTOMS

### Heart

- Y N** Do you ever feel your heart skip a beat? How often? \_\_\_\_\_  
For how many years? \_\_\_\_\_
- Y N** Do you have chest pain? How often? \_\_\_\_\_  
For how many years? \_\_\_\_\_  
Is the pain sharp / stabbing / dull / aching? \_\_\_\_\_ Does it radiate to your neck, back, or shoulders?
- Y N** How long does the pain last? \_\_\_\_\_
- Y N** Do you feel like you are going to pass out?

### Gastrointestinal System

- Y N** Do you have abdominal cramping, bloating, excessive belching or intestinal gas?  
How often? \_\_\_\_\_ x/week \_\_\_\_\_ How long? \_\_\_\_\_

### Urinary Tract

- Y N** Have you ever had bladder infections / kidney infections?  
How many x/year? \_\_\_\_\_ For how many years? \_\_\_\_\_

**Y N** Have you ever had kidney stones? How many times? \_\_\_\_\_  
Year of last episode \_\_\_\_\_

**Y N** Do you have burning upon urination?

**Y N** Do you have increased frequency of urination?

**Yeast/Skin Fungus**

**Y N** Have you ever had a vaginal yeast infection? How many times? \_\_\_\_\_  
How many x/year? \_\_\_\_\_ How many years? \_\_\_\_\_  
Between what years? \_\_\_\_\_ and \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Environmental Allergies**

**Y N** Do you have environmental allergies such as: pollen, mold, cat, or dog?

**Y N** Have you had an allergy test performed? If yes, date: \_\_\_\_\_

Please list allergies below

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_
- 9. \_\_\_\_\_

**Thyroid**

**Y N** Have you been diagnosed with a thyroid disorder? Year diagnosed \_\_\_\_\_

**Y N** Were you diagnosed with hyperthyroidism

**Y N** Were you diagnosed with hypothyroidism

**Y N** Did you ever take thyroid medication? What year did you quit? \_\_\_\_\_  
Name of medicine \_\_\_\_\_ Dose \_\_\_\_\_ mg

**Malaise/Fatigue**

**Y N** Do you feel you should have more energy?  
What is your average energy level on a scale of 0 to 10 with 10 meaning brimming with energy  
and 1 or 2 meaning the inability to get out of bed?  
ENERGY LEVEL 0-10 \_\_\_\_\_ /10 For how many years? \_\_\_\_\_

**Hair Condition**

**Y N** Do you have coarse or fine hair? For how many years? \_\_\_\_\_

**Y N** Have you ever had significant hair loss?  
How long? \_\_\_\_\_ months \_\_\_\_\_ years

**Weight**

Y N Have you had significant weight gain? How many pounds? \_\_\_\_\_  
Since what year? \_\_\_\_\_

Y N Do you have difficulty losing weight? How long?  
Y N Are you interested in medical weight loss? \_\_\_\_\_

**Mood**

Y N Do you ever feel discouraged, blue or depressed more than 10% of the time?  
What percent of the time? \_\_\_\_\_ % For how many years? \_\_\_\_\_  
Y N Have you ever taken anti-depressants?  
Which one(s)? \_\_\_\_\_  
Between what \_\_\_\_\_ y.o. and \_\_\_\_\_ y.o. ages? \_\_\_\_\_

**Skin**

Y N Do you have dry skin? For how many years? \_\_\_\_\_

**Sleep**

Y N Do you have insomnia or restless sleep? How many years? \_\_\_\_\_  
Y N Do feel tired after a full night's sleep? How many years? \_\_\_\_\_  
Y N Do you have afternoon fatigue? \_\_\_\_\_  
How many hours of sleep do you \_\_\_\_\_ hours/night? require? \_\_\_\_\_

**MENSTRUAL HISTORY - PREMENOPAUSAL QUESTIONS**

**Pregnancy**

Date of last normal menstrual period? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
At what age did you enter puberty? \_\_\_\_\_ y.o.  
How many pregnancies? \_\_\_\_\_ live births? \_\_\_\_\_ miscarriages?  
Date of last child's birth \_\_\_\_\_ Your age then? \_\_\_\_\_  
Y N Did you have difficulty becoming pregnant?  
Y N Did you ever receive infertility treatment? What kind? \_\_\_\_\_

**Birth Control**

Y N Have you had bilateral tubal ligation? If yes, \_\_\_\_\_ / \_\_\_\_\_ (mo/yr) when? \_\_\_\_\_  
Y N Are you currently using an IUD?

- Y N** Have you ever taken Depo- Provera?  
**Y N** Did you ever take birth control pills?  
 If yes, for how long? \_\_\_\_\_ mos \_\_\_\_\_ yrs  
 Date you discontinued BCP \_\_\_\_\_ / \_\_\_\_\_  
**Y N** Are you currently taking any female hormones (progesterone or estrogen)?  
 If yes, which ones? \_\_\_\_\_  
 For how long? \_\_\_\_\_

**Pap Smear**

- Y N** Have you had an abnormal pap smear?  
 If yes, when? \_\_\_\_\_ / \_\_\_\_\_ (mo/yr)  
**Y N** Was your most recent pap smear normal?  
 Date: \_\_\_\_\_ / \_\_\_\_\_ (mo/yr)

**Menstrual Periods**

- Y N** Do your menstrual periods occur at the same time each month?  
 If no, what is the shortest number of days between periods? \_\_\_\_\_  
 What is the longest number of days between periods? \_\_\_\_\_  
 How long have your menstrual cycles been \_\_\_\_\_ months \_\_\_\_\_ years  
 irregular? \_\_\_\_\_  
**Y N** Were your menstrual cycles ever regular?  
 How many days do your periods last? \_\_\_\_\_ days  
**Y N** Are your periods heavier or lighter than in the past?  
 If yes, when did they change? \_\_\_\_\_ (mo/yr)  
**Y N** Do you have intermenstrual bleeding that occurs between your normal periods?  
 If yes, for how long has this \_\_\_\_\_ month \_\_\_\_\_ years  
 occurred? \_\_\_\_\_ s \_\_\_\_\_

**Premenstrual Syndrome**

- Y N** Do you have breast tenderness prior to your period?  
 If yes, how many days prior to your period does it begin? \_\_\_\_\_ days  
 For how long has this \_\_\_\_\_ months \_\_\_\_\_ years  
 occurred? \_\_\_\_\_  
**Y N** Do you have mood swings to your period?  
 If yes, how many days prior to your period does it \_\_\_\_\_ days  
 begin? \_\_\_\_\_  
 For how long has this \_\_\_\_\_ months \_\_\_\_\_ years  
 occurred? \_\_\_\_\_  
**Y N** Do you have fluid retention prior to your period?  
 If yes, how many days prior to your period does it \_\_\_\_\_ days  
 begin? \_\_\_\_\_  
 For how long has this \_\_\_\_\_ months \_\_\_\_\_ years

occurred? \_\_\_\_\_  
**Y N** Do you have weight gain prior to your period?  
Approximately how many pounds do you gain prior to your \_\_\_\_\_ lbs.  
periods?  
For how long has this \_\_\_\_\_ months \_\_\_\_\_ years  
occurred?

**Y N** Do you crave sweets or bread products prior to your periods?

**Y N** Do you develop headaches (not migraine) prior to your periods?  
If yes, how many days prior to your period do they \_\_\_\_\_ days  
begin?  
For how long has this \_\_\_\_\_ months \_\_\_\_\_ years  
occurred?

**Y N** Do you have menstrual cramps? \_\_\_\_\_  
If yes, for how many days? \_\_\_\_\_

**Y N** Do you experience hot flashes? \_\_\_\_\_  
For how long? \_\_\_\_\_ months \_\_\_\_\_ years

**Y N** Do you have night sweats? \_\_\_\_\_  
For how many years? \_\_\_\_\_

**Y N** Have any of the above symptoms ever caused you to miss work or school, or  
cause you to be unable to do daily functions?

### Estrogen Dominance

**Y N** Do you have fibrocystic breast disease? \_\_\_\_\_  
how long? \_\_\_\_\_ months \_\_\_\_\_ years

**Y N** Have you ever had endometriosis? \_\_\_\_\_  
how long? \_\_\_\_\_ months \_\_\_\_\_ years

**Y N** Do you have uterine fibroids? \_\_\_\_\_  
how long? \_\_\_\_\_ months \_\_\_\_\_ years

**Y N** Have you had ovarian cysts? \_\_\_\_\_  
How many times? \_\_\_\_\_  
Which side? \_\_\_\_\_ left \_\_\_\_\_ right  
\_\_\_\_\_ t \_\_\_\_\_

**Y N** Have you developed dark hair on your face?  
How long ago did it  
begin? \_\_\_\_\_ months \_\_\_\_\_ years

**Y N** Have you developed dark hair on your breasts?  
How long ago did it  
begin? \_\_\_\_\_ months \_\_\_\_\_ years

**Y N** Have you had a decrease in sexual  
desire?  
For how long? \_\_\_\_\_ months \_\_\_\_\_ years

**Y N** Have you ever had pain or discomfort during or after intercourse?

**Y N** Due to vaginal dryness?  
For how long? \_\_\_\_\_ months \_\_\_\_\_ years

**Bone Density**

**Y N** Have you ever been diagnosed with osteoporosis?

**Recurrent Medications**

**Y N** Do you currently take prescription medication? Please list the strength, times/day taken, and number of years taken:

- |          |          |
|----------|----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| _____    | _____    |

**Y N** Do you currently take vitamins or supplements? Please list the strength, times/day taken, and number of years taken:

- |          |          |
|----------|----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |

## Yeast Overgrowth Questionnaire

This Yeast Questionnaire lists symptoms and other factors most commonly found in people suffering from Yeast Overgrowth. Read each question carefully and total the number that applies to you.

Do you have fatigue?	3
Do you feel lethargic?	2
Do you have recurrent vaginal yeast infections?	4
Have you taken antibiotics multiple times during your life?	3
Do you have abdominal bloating, cramping or gas?	3
Do you have indigestion or heartburn?	2
Do you have abnormal bodily reactions to wine, beer or alcoholic beverages, such as flushing, headache, sinus congestion or itchy skin?	2
Do you crave sugar or bread products?	2
Do you have difficulty concentrating?	1
Do you have depressed moods?	1
Do you develop skin rashes or hives?	2
Do you have athlete's foot?	4
Do you have jock itch?	4
Do you have rectal itching?	3
Do you have fungal infections under the toenails or fingernails?	3
Do you have allergy symptoms?	1
Do you have recurrent respiratory infections?	1
Do you have joint pain?	1
Do you have muscle pain?	1

**Total:** \_\_\_\_\_

\* < 10 — It is not likely that you have yeast overgrowth.

\* 10-16 — Yeast overgrowth is a possibility.

\* > 16 — Yeast overgrowth is very likely.

## Low Thyroid Function

This Thyroid Questionnaire lists symptoms and other factors most commonly found in people suffering from low thyroid, or hypothyroidism. Read each question carefully and total the number that applies to you.

Do you have fatigue?	4
Do you have elevated cholesterol?	4
Do you have difficulty losing weight?	2
Do you have cold hands and feet?	2
Are you sensitive to the cold?	2
2Do you have difficulty thinking?	2
Do you find it hard to concentrate?	2
Do you experience brain fog?	2
Do you have poor short term memory?	2
Do you have depressed moods?	2
Are you experiencing hair loss?	2
Do you have less than one bowel movement a day?	2
Do you have dry skin?	2
Does your skin itch in the winter?	1
Do you have fluid retention?	2
Do you have recurrent headaches?	1
Do you sleep restlessly?	1
Are you tired when you awaken?	2
Do you have afternoon fatigue?	2
Do you experience tingling or numbness in your hands or feet?	2
Do you have decreased sweating?	2
Have you had problems with infertility or miscarriages?	2
Do you have recurrent infections?	2
Do your muscles ache?	2
Do you have joint pain?	2
Do you have thinning of your eyebrows or eyelashes?	2
Is your tongue enlarged with teeth indentations?	2
Is your skin pasty, puffy or pale?	2
Do you have decreased body hair?	2
Is your voice hoarse?	1
Do you have a slow pulse?	2
Do you have low blood pressure?	2
Does your body temperature run below the normal 98.6°?	4
Do you have sleep apnea?	2

**Total:** \_\_\_\_\_

- \* < 9 — It is not likely that you have low thyroid function.
- \* 9-28 — Low thyroid function is a possibility.
- \* > 28 — Low thyroid function is very likely.

## Estrogen Dominance/Progesterone Deficiency

This Estrogen Dominance Questionnaire lists symptoms and other factors most commonly found in women suffering from Estrogen Dominance and/or Progesterone Deficiency. Read each question carefully and check the box if it applies to you.

Do you have premenstrual breast tenderness?	4
Do you have premenstrual mood swings?	4
Do you have premenstrual fluid retention and weight gain?	4
Do you have premenstrual headaches?	4
Do you have migraine headaches?	3
Do you have severe menstrual cramps?	4
Do you have heavy periods with clotting?	3
Do you have irregular menstrual cycles?	3
Do you have uterine fibroids?	3
Do you have fibrocystic breast disease?	3
Do you have endometriosis?	2
Have you had problems with infertility?	2
Have you had more than one miscarriage?	2
Do you have joint pain?	1
Do you have muscle pain?	1
Do you have decreased libido?	3
Do you have anxiety or panic attacks?	2

**Total** \_\_\_\_\_

- \* 0 < 5 — It is not likely that you have estrogen dominance.
- \* 5-8 — Estrogen dominance is a possibility.
- \* 9-20 — Estrogen dominance is probable.
- \* > 20 — Indicates that estrogen dominance is very likely.

## Female Hormonal Imbalance

This questionnaire lists symptoms and other factors most commonly found in women who are either perimenopausal or menopausal, and suffering from low estrogen. Read each question carefully and check the box if it applies to you.

Do you have hot flashes?	4
Do you have night sweats?	4
Do you have vaginal dryness?	3
Do you urinate frequently?	2
Are you depressed?	2
Do you have difficulty sleeping?	3
Have you lost interest in sex?	2
Have your periods ceased?	4

**Total** \_\_\_\_\_

- \* < 5 — It is not likely that you have low estrogen.
- \* 5-9 — Low estrogen is a possibility.
- \* > 9 — Low estrogen is very likely.

## Low Testosterone Levels

This questionnaire lists symptoms and other factors most commonly found in women suffering from low testosterone. Read each question carefully and check the box if it applies to you.

Do you have fatigue?	2
Do you have a lack of drive?	3
Do you lack initiative?	3
Are you less assertive?	3
Do you have a decline in your sense of well being?	2
Do you have depressed moods?	2
Are you frequently irritable?	2
Has your self-confidence declined?	2
Do you find it difficult to set goals?	2
Do you have a difficult time making decisions?	2
Have you had a decline in your mental sharpness?	2
Has your stamina and endurance lessened?	2
Have you lost muscle mass, strength or tone?	4
Have you gained body fat around your waist?	2
Do you have elevated cholesterol?	2
Do you have elevated cholesterol?	4
Has your libido decreased?	2
Has your sexual ability declined?	2

**Total** \_\_\_\_\_

- \* < 7 — It is not likely that you have low testosterone.
- \* 7-20 — Low testosterone is a possibility.
- \* > 20 — Low testosterone is very likely.

## Adrenal Fatigue

This Adrenal Fatigue Questionnaire lists symptoms and other factors most commonly found in people suffering from adrenal fatigue. Read each question carefully and check the box if it applies to you.

Do you have fatigue?	3
Do you have allergies?	3
Do you have asthma?	3
Do you have recurrent infections?	3
Are you under severe emotional stress?	3
Do you suffer from chronic pain or physical stress?	3
Do you have low blood pressure?	2
Do you have a low pulse rate (less than 70 bpm with no exercise)?	2
When you rise quickly, do you feel as though you might pass out?	2
Do you have depressed moods?	2
Do you have joint pain?	2
Do you have muscle pain?	2
Do you have low libido?	2
Do you have hair loss?	2
Do you have anxiety attacks?	2

**Total:** \_\_\_\_\_

\* < 7 — It is not likely that you have adrenal fatigue.

\* 7-12 — Adrenal fatigue is a possibility.

\* > 12 — Adrenal fatigue is very likely.

## Allergies

This Allergy Questionnaire lists symptoms and other factors most commonly found in people suffering from some form of allergy.

Do you have fatigue?	3
Do you have frequent headaches?	2
Do you have sneezing, post nasal drainage or itching of the nose?	4
Do you have frequent colds?	2
Do you experience dizziness?	4
Do you get sinus infections every year?	1
Do your eyes itch, water, get red or swell?	4
Do you have recurrent ear infections?	2
Do you have asthma, wheezing, tightness in the chest or chronic cough?	4
Do you have skin problems such as eczema, skin rashes, itching or hives?	3
Do you have indigestion, bloating, diarrhea or constipation?	1
Do your symptoms worsen during a particular season, such as the spring or fall?	4
Do your symptoms change when you go indoors or outdoors?	3
Are your symptoms worse in parks or grassy areas?	4
Are your symptoms worse in the bedroom after going to bed, or in the morning upon arising?	2
Do you awaken in the middle of the night with congestion?	2
Are your symptoms worse when you come into contact with dust?	4
Are your symptoms worse around animals?	2
Do you have any blood relatives with allergies?	2
Do you have mood swings or feel depressed for no reason?	1
Do you have recurrent yeast infections, jock itch, Athlete's foot or fungus under your toenails?	2
Do you develop symptoms after eating or drinking certain foods?	2
Do you sometimes feel stimulated, hyperactive or fatigued after meals?	2
Do you have dark circles under your eyes?	2
Do you have a crease across the bridge of your nose?	2

**Total** \_\_\_\_\_

\* < 9 — It is not likely that you have allergies.

\* 9-12 — Possibility of allergies.

\* 13-30 — Allergies are probable.

\* > 30 — Allergies are very likely.

## Hormone Checklist

Check **ALL** applicable symptoms of **each** category:

### Estrogen Deficiency

- |  |  |
|--|--|
| <input type="checkbox"/> Hot Flashes     | <input type="checkbox"/> Depressed         |
| <input type="checkbox"/> Night Sweats    | <input type="checkbox"/> Sleep Disturbance |
| <input type="checkbox"/> Vaginal Dryness | <input type="checkbox"/> Heart Palpitation |
| <input type="checkbox"/> Foggy Thinking  | <input type="checkbox"/> Bone Loss         |
| <input type="checkbox"/> Memory Lapses   | <input type="checkbox"/> Dry Skin/Hair     |
| <input type="checkbox"/> Incontinence    | <input type="checkbox"/> Headaches         |
| <input type="checkbox"/> Tearful         |  |

### Estrogen Excess

- |  |  |
|--|--|
| <input type="checkbox"/> Mood Swings (PMS)     | <input type="checkbox"/> Fibrocystic Breasts |
| <input type="checkbox"/> Tender Breasts        | <input type="checkbox"/> Uterine Fibroids    |
| <input type="checkbox"/> Water Retention       | <input type="checkbox"/> Weight Gain (Hips)  |
| <input type="checkbox"/> Nervous               | <input type="checkbox"/> Bleeding Changes    |
| <input type="checkbox"/> Irritable             | <input type="checkbox"/> Headaches           |
| <input type="checkbox"/> Sleep Disturbances    | <input type="checkbox"/> Breast Cancer       |
| <input type="checkbox"/> Cold Body Temperature | <input type="checkbox"/> Weight Gain waist   |

### PROGESTERONE DEFICIENCY

- |  |  |
|--|--|
| <input type="checkbox"/> Candida Infections  | <input type="checkbox"/> Fluid Retention |
| <input type="checkbox"/> Fibrocystic Breasts | <input type="checkbox"/> Arthritis       |
| <input type="checkbox"/> Hair Loss           | <input type="checkbox"/> Endometriosis   |
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Stressed easily |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Water retention |

### PROGESTERONE DEFICIENCY

- |   |  |
|---|--|
| <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Break-thru bleeding |
| <input type="checkbox"/> Weight Gain        | <input type="checkbox"/> Fibroids            |
| <input type="checkbox"/> Heavy Periods      | <input type="checkbox"/> PMS                 |
| <input type="checkbox"/> Irritability       | <input type="checkbox"/> Irregular cycles    |
| <input type="checkbox"/> Cramps             | <input type="checkbox"/> Hypothyroidism      |

### Androgen Deficiency

- |  |  |
|--|--|
| <input type="checkbox"/> Low libido            | <input type="checkbox"/> Depressed             |
| <input type="checkbox"/> Vaginal Dryness       | <input type="checkbox"/> Sleep Disturbance     |
| <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Thinning Pubic Hair   |
| <input type="checkbox"/> Aches/Pains/Arthritis | <input type="checkbox"/> Decreased Muscle Mass |
| <input type="checkbox"/> Memory Lapses         | <input type="checkbox"/> Bone Loss             |
| <input type="checkbox"/> Incontinence          | <input type="checkbox"/> Thinning Skin         |
| <input type="checkbox"/> Heart Palpitations    | <input type="checkbox"/> Fibromyalgia          |

### Androgen Excess

- |   |  |
|---|--|
| <input type="checkbox"/> Excessive Facial Hair  | <input type="checkbox"/> Oily Skin         |
| <input type="checkbox"/> Excessive Body Hair    | <input type="checkbox"/> Ovarian Cysts     |
| <input type="checkbox"/> Increased Acne         | <input type="checkbox"/> Hair Loss scalp   |
| <input type="checkbox"/> Breast Cancer          | <input type="checkbox"/> Nervous/Irritable |
| <input type="checkbox"/> Elevated Triglycerides |  |

### Cortisol Deficiency

- |   |   |
|---|---|
| <input type="checkbox"/> Fatigue              | <input type="checkbox"/> Cold Body Temp.    |
| <input type="checkbox"/> Sugar Cravings       | <input type="checkbox"/> Irritable          |
| <input type="checkbox"/> Allergies            | <input type="checkbox"/> Arthritis          |
| <input type="checkbox"/> Chemical Sensitivity | <input type="checkbox"/> Heart Palpitations |
| <input type="checkbox"/> Stress               | <input type="checkbox"/> Aches / Pains      |

### Cortisol Excess

- |   |  |
|---|--|
| <input type="checkbox"/> Sleep Disturbances     | <input type="checkbox"/> Heart Palpitation     |
| <input type="checkbox"/> Bone Loss              | <input type="checkbox"/> Headaches             |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Stress                |
| <input type="checkbox"/> Weight Gain/Loss       | <input type="checkbox"/> Cold Body Temp        |
| <input type="checkbox"/> Muscle Mass Loss       | <input type="checkbox"/> Sugar Cravings        |
| <input type="checkbox"/> Thinning Skin          | <input type="checkbox"/> Low Libido            |
| <input type="checkbox"/> Elevated Triglycerides | <input type="checkbox"/> Hair Loss             |
| <input type="checkbox"/> Breast Cancer          | <input type="checkbox"/> Increased Facial Hair |
| <input type="checkbox"/> Irritable              | <input type="checkbox"/> Increased Body Hair   |
| <input type="checkbox"/> Anxious                | <input type="checkbox"/> Acne                  |
| <input type="checkbox"/> Memory Lapse           | <input type="checkbox"/> Nervous               |

### THYROID DEFICIENCY

- |   |   |
|---|---|
| <input type="checkbox"/> Tired or Exhausted       | <input type="checkbox"/> Difficult to Concentrate |
| <input type="checkbox"/> Sad or Depressed         | <input type="checkbox"/> Mood Changes             |
| <input type="checkbox"/> Cold Body Temp. eye/face | <input type="checkbox"/> Swelling/Puffy           |
| <input type="checkbox"/> Cold Hands & Feet        | <input type="checkbox"/> Low Blood Pressure       |
| <input type="checkbox"/> Weight Gain              | <input type="checkbox"/> Slow Pulse Rate          |
| <input type="checkbox"/> Can't Lose Weight        | <input type="checkbox"/> Decreased Sweating       |
| <input type="checkbox"/> Memory Lapse             | <input type="checkbox"/> Hair Dry/ Brittle        |
| <input type="checkbox"/> Forgetfulness            | <input type="checkbox"/> Hair Loss                |

### THYROID DEFICIENCY

- |  |   |
|--|---|
| <input type="checkbox"/> Nails breaking/ Brittle | <input type="checkbox"/> Infertility Problems |
| <input type="checkbox"/> Aches / Pains           | <input type="checkbox"/> Slowed Reflexes      |
| <input type="checkbox"/> Low Libido              | <input type="checkbox"/> Constipation         |
| <input type="checkbox"/> Heart Palpitation       | <input type="checkbox"/> Thick Tongue         |
| <input type="checkbox"/> Sleep Disturbances      | <input type="checkbox"/> Slow Ankle Reflex    |
| <input type="checkbox"/> Bone Loss               | <input type="checkbox"/> Hoarseness           |
| <input type="checkbox"/> Decreased Muscle Mass   |   |
| <input type="checkbox"/> Thinning Skin           |   |