Female Hormone and Female Specific Questionnaire

After appropriate testing is performed, the use of natural herbs or nutrients, natural plant hormones, or bio-identical hormones may be indicated.

Female Questionnaire

Please Circle any of the following that pertain to you in a cyclic or recurrent manner:

I (P)	II (E)
Heavy menstrual flow	Long cycles (34+ days)
Prolonged menstruation	Scanty menstrual flow
Fluid retention	Absence of menstruation
Breast tenderness	Severe, spastic uterine cramping
Dull, achy uterine cramping	Blood sugar imbalances, hypoglycemia
Emotional Irritability	Fatigue/ Ennui
Aggressive temperament	Low libido/sex drive
Tension-type headaches	Depression
Food cravings	Forgetfulness
Premenstrual skin eruptions	Mood Swings
Uterine fibroids	Infertility Issues
Fibrocycstic breasts	chronically tired, fatigued
Ovarian cysts	

Hot flashes	Depression	Anxiety	Insomnia	Low libido	Vaginal Dryness	Vertigo
Osteoporosis/osteopenia	Increased Perspiration		Heart Palpitations		Tinnitus	Hair loss
Poor Digestion	Trouble Eating	Fatty/Greasy Foods	Abdominal or stomach pains		Excessive Gas	
Bloating	Constipation	Diarrhea	Low back pain	Pelvic Pain	Pelvic Floor Pain	

The following score sheet will help you to determine whether hormone testing is needed, and which tests to order. Each category is divided into hormone deficiency and excess, as each has a different subset of symptoms. Score the symptoms, which apply, to you as:

0(none) 1(mild) 2 (moderate to severe)

Androgens (DHEA and Testosterone)

Androgen Deficiency

____Low Libido
____Vaginal Dryness
____Foggy Thinking
____Fatigue
____Aches/Pains
____Memory Lapses
____Incontinence
____Depressed
____Sleep Disturbances
____Bone Loss
____Decreased Muscle Mass
____Thinning Skin

Androgen Excess

____Excessive facial/Body Hair
____Loss of Scalp Hair
____Increased Acne
____Oily Skin

Cortisol

Cortisol Deficiency

____Fatigue
____Sugar Cravings
____Allergies (Food, skin, airborne)
____Chemical Sensitivity (dyes, perfumes, smoke)
____Stress
____Cold Body Temperature
____Heart Palpitations
____Aches/Pains
____Arthritis

Cortisol Excess

____Sleep Disturbances
____Bone Loss
____Fatigue
____Weight Gain in Waist
____Loss of Muscle Mass
____Thinning Skin

Thyroid

Thyroid Deficiency

____Fatigue
____Weight Gain
____Cold hands or feet
____Loss of eyebrow hairs
____Low sex drive
____Mental fogginess/trouble with focus
____Cold sensitive
____Throat swelling or trouble swallowing

Thyroid Excess

____Heat sensitive
____Hyperreflexive
____Jumpy/jittery
____Heart palpitations
____Weight Loss

1. I take, or recently have taken, birth control pills Yes No Type_____
2. Have you had children? Yes No If yes, how many? _____
3. Have you had a caesarian section (C-section)? _____
4. Have you had an episiotomy? _____
5. Do you have breast implants? Yes No
6. Are you on birth control of some sort? IUD Birth Control Pills Other:_____
7. Have you had recurrent miscarriage(s)? Yes No
8. Are you <u>postmenopausal</u> or <u>perimenopausal</u>? Yes No If so, which?
9. Are you having trouble conceiving a child? Yes No How long have you been trying?_____
10. Do you have recurrent bladder or urinary tract infections? Yes No
11. When was your last comprehensive blood work up and/or urinalysis? Date: _____ Never
12. When was your last Thyroid Panel blood test (TSH, T3, T4, TPO, thyroid antibodies) _____ Never
13. When was your last Pap Smear? Date: _____ Never
14. When was your latest mammogram, thermographic mammogram, or MRI mammogram?

    Date: _____ Never

15. Do you have any root canals? #_____ Fillings/Amalgams? # _____

16. Have you had B12/Methionine/Choline/Inositol/Carnitine/B complex/Tyrosine injections before?

17. Have you had a history of exposure to Paint - Toxic Metals - New Carpet - Formaldehyde- Smoke – Car Exhaust - Chlorine – Cleaning Fluids – Solvents – Molds – Dry Cleaned clothing

18. Are you sensitive to perfumes, smells, scented candles, room sprays, etc.? Yes No

19. What Medications/herbs/foods are you allergic too:_____

20. Do you get headaches with Chocolate Wine Cheese Dried Fruit Cured Meats

21. Do you regularly drink "diet" colas or use artificial sweeteners? Types:_____

22. What is your approximate height _____ft _____inches, and weight_____ lb

23. Circle any of the following that you have regularly:

Poor Digestion	Trouble Eating	Fatty/Greasy Foods	Abdominal or stomach pains		Excessive Gas
Bloating	Constipation	Diarrhea	Low back pain	Pelvic Pain	Pelvic Floor Pain

----------**(The remainder of this page will be filled out by the physician)**----------

Name:_____ Date:_____

Weight: _____ BMI:_____

Fat % _____ Waist: _____ Hip_____

Ratio: _____

Pulse Ox: _____Pulse: _____ Temp:_____ Resp:_____ BP: _____ →ortho:_____

Notes:

TX:

Injection: B12 MIC/SuperB/Carnitine Tyrosine MgCl CaGluconate Tyrptophan

Other:

Acupuncture:

Hormones: Progesterone Estrogen DHEA Adrenal extract DHEA/Hoodia/EGCG/ALA cream

Thymus extract

Manipulation: C 1 2 3 4 5 6 7 T 1 2 3 4 5 6 7 8 9 10 11 12 L 1 2 3 4 5 LPIN RAIN Extremity:

Homeopathics: Hormeel/ Ignatia homaccord/Ovarium compositum/Thuja Forte/ Thyroidea compositum

RX: Lido5%/Keto20%/Cyclo2% Cyclo 5/10mg tid Ibu 600qid Nap220 tid

Other: