Name: _____Age:_____ Initial (1st) Date: _____ *Follow-up (2nd) Date*: _____

WOMEN SYMPTOM REVIEW (Men Turn Page Over). ONLY 1 FORM NEEDED

Check NONE if no symptoms. Check Mild to Moderate or Severe symptoms, if currently experiencing. 1st or 2nd visit.

Initial visit	*Follow-up*		**Initial visit 1st visit**	**Initial visit**	*Follow-up 2nd visit*	*Follow-up*	
None	*None*	**Symptoms**	**Mild to Mod**	**Severe**	*Mild to Mod*	*Severe*	
		Hot Flashes					**Low Estrogen**
		Night Sweats					
		Vaginal Dryness					
		Incontinence Bladder					
		Bleeding Changes Irregular					**Estrogen Dominance (too much estrogen)** **Low Progesterone (protective hormone)**
		Uterine Fibroids (growth)					
		Water Retention / Bloated					
		Tender Breasts					
		Cysts or Lumps Breasts					
		Ovarian Cysts					
		Increased Forgetfulness					
		Foggy Thinking / Memory Fog					
		Tearful / Crying / Depressed					
		Mood Swings					
		Stress					**Adrenal Cortisol Imbalance (stress gland)**
		Morning Fatigue					
		Difficulty Sleeping					
		Decreased Stamina					
		Anxious					
		Irritable					
		Nervous					
		Fibromyalgia / Chronic Fatigue					
		Allergies					
		Headaches					
		Sugar Cravings					
		Dizzy Spells					
		Cold Body Temperature					**Thyroid & Iodine Poor Balance**
		Enlarged Thyroid / Goiter					
		Hoarse					
		Hair Dry or Losing Hair					
		Nails Breaking or Brittle					
		Constipation					
		Slow Pulse Rate					
		Rapid Heartbeat					
		Heart Palpitations					
		Infertility Problems					
		Acne / Breaking out					**Metabolic Syndrome (high sugar)** **High Androgens**
		Increased Facial/Body Hair					
		Scalp Hair Loss					
		Weight Gain – Hips					
		Weight Gain – Waist					
		High Cholesterol					
		Elevated Triglycerides (Fats)					
		Decreased Libido / Sex Drive					**Low Androgens (Testosterone) Other Hormonal Imbalance**
		Decreased Muscle Size					
		Thinning Skin					
		Ringing in Ears					
		Rapid Aging					
		Aches & Pains					
		Bone Loss or Osteoporosis					

Additional Symptoms: _____