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
Fibrocystic 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

Androgen Excess
___Bone Loss
___Decreased Muscle Mass
___Thinning Skin
___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

**Cortisol Excess**
- Arthritis
- Sleep Disturbances
- Bone Loss
- Fatigue
- Weight Loss 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 postmenopausal or perimenopausal? 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
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: