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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

Mark 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

Mark 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

Mark 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 _____