

## ***QUICK REFERENCE HORMONAL SNAP SHOT***

Name \_\_\_\_\_ DATE \_\_\_\_\_

### **Group 1**

<input type="radio"/> PMS	<input type="radio"/> Cyclical headache
<input type="radio"/> Early Miscarriage	<input type="radio"/> Insomnia
<input type="radio"/> Unexplained weight gain	<input type="radio"/> Painful and / or lumpy breasts
<input type="radio"/> Anxiety	<input type="radio"/> Infertility

Number of boxes checked in this section \_\_\_\_\_

### **Group 2**

<input type="radio"/> Vaginal Dryness	<input type="radio"/> Night Sweats
<input type="radio"/> Painful Intercourse	<input type="radio"/> Memory Loss
<input type="radio"/> Bladder Infections	<input type="radio"/> Lethargic Depression
<input type="radio"/> Hot Flashes	

Number of boxes checked in this section \_\_\_\_\_

### **Group 3**

<input type="radio"/> Puffiness or bloating	<input type="radio"/> Breast Tenderness
<input type="radio"/> Rapid weight gain in hips & abdomen	<input type="radio"/> Migraine Headaches
<input type="radio"/> Mood Swings / Weepiness	<input type="radio"/> Foggy Thinking
<input type="radio"/> Anxious Depression	<input type="radio"/> Red Flush on Face
<input type="radio"/> Insomnia	<input type="radio"/> Fibrocystic Breasts
<input type="radio"/> Gallbladder problems	<input type="radio"/> Water Retention
<input type="radio"/> Cervical Dysplasia( abnormal pap)	<input type="radio"/> Fibromyalgia
<input type="radio"/> Heavy Bleeding	<input type="radio"/> Hysterectomy

Number of boxes checked in this section \_\_\_\_\_

**Group 4**

- A combination of groups 1 & 3 totaling at least 2 in each group

**Group 5**

<input type="checkbox"/> Acne	<input type="checkbox"/> Ovarian Cysts
<input type="checkbox"/> Excessive hair on face and arms	<input type="checkbox"/> Thinning Hair on Head
<input type="checkbox"/> Polycystic ovary syndrome ( PCOS)	<input type="checkbox"/> Discomfort in Lower Abdomen
<input type="checkbox"/> Low and Unstable Blood Sugar	<input type="checkbox"/> Infertility

**Number of boxes checked in this section** \_\_\_\_\_

**Group 6**

<input type="checkbox"/> Debilitating Fatigue	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Foggy Thinking	<input type="checkbox"/> Brown Spots on the Face
<input type="checkbox"/> Thin or Dry Skin	<input type="checkbox"/> Unstable Blood Sugar
<input type="checkbox"/> Intolerance for Exercise	<input type="checkbox"/> Brown Spots on Body

**Number of boxes checked in this section** \_\_\_\_\_

**POINTS:**

**NOTES:**

Group 1 \_\_\_\_\_

Group 2 \_\_\_\_\_

Group 3 \_\_\_\_\_

Group 4 \_\_\_\_\_

Group 5 \_\_\_\_\_

Group 6 \_\_\_\_\_