

Check applicable symptoms of each category:

Name _____ Date _____

Estrogen Deficiency

<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Depressed
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Sleep Disturbance
<input type="checkbox"/> Vaginal Dryness	<input type="checkbox"/> Heart Palpitations
<input type="checkbox"/> Foggy Thinking	<input type="checkbox"/> Bone Loss
<input type="checkbox"/> Memory Lapses	<input type="checkbox"/> Dry Skin/Hair
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Headaches
<input type="checkbox"/> Tearful	

Estrogen Excess

<input type="checkbox"/> Mood Swings (PMS)	<input type="checkbox"/> Fibrocystic Breasts
<input type="checkbox"/> Tender Breasts	<input type="checkbox"/> Uterine Fibroids
<input type="checkbox"/> Water Retention	<input type="checkbox"/> Weight Gain (hips)
<input type="checkbox"/> Nervous	<input type="checkbox"/> Bleeding Changes
<input type="checkbox"/> Irritable	<input type="checkbox"/> Headaches
<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Breast Cancer
<input type="checkbox"/> Cold Body Temperature	<input type="checkbox"/> Weight Gain (waist)
<input type="checkbox"/> Elevated Triglycerides	<input type="checkbox"/> Low Libido

Progesterone Deficiency

<input type="checkbox"/> Candida Infections	<input type="checkbox"/> Fluid Retention	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Break-thru Bleeding
<input type="checkbox"/> Fibrocystic Breasts	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Fibroids
<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Heavy Periods	<input type="checkbox"/> PMS
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Stressed Easily	<input type="checkbox"/> Irritability	<input type="checkbox"/> Irregular Periods
<input type="checkbox"/> Headaches	<input type="checkbox"/> Water Retention	<input type="checkbox"/> Cramps	<input type="checkbox"/> Hypothyroid

Androgens (DHEA-S) and Testosterone

Androgen Deficiency

<input type="checkbox"/> Low Libido	<input type="checkbox"/> Depressed
<input type="checkbox"/> Vaginal Dryness	<input type="checkbox"/> Sleep Disturbances
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Thinning Pubic Hair
<input type="checkbox"/> Aches/Pains/Arthritis	<input type="checkbox"/> Bone Loss
<input type="checkbox"/> Memory Lapses	<input type="checkbox"/> Decreased Muscle Mass
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Thinning Skin
<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Fibromyalgia

Androgen Excess

<input type="checkbox"/> Excessive Facial Hair	<input type="checkbox"/> Oily Skin
<input type="checkbox"/> Excessive Body Hair	<input type="checkbox"/> Ovarian Cysts
<input type="checkbox"/> Increased Acne	<input type="checkbox"/> Hair Loss (scalp)
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Nervous, Irritable
<input type="checkbox"/> Elevated Triglycerides	

Cortisol Deficiency

<input type="checkbox"/> Fatigue	<input type="checkbox"/> Cold Body Temp.
<input type="checkbox"/> Sugar Cravings	<input type="checkbox"/> Irritable
<input type="checkbox"/> Allergies	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Chemical Sensitivity	<input type="checkbox"/> Heart Palpitations
<input type="checkbox"/> Stress	<input type="checkbox"/> Aches/Pains

Cortisol Excess

<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Bone Loss
<input type="checkbox"/> Headaches	<input type="checkbox"/> Sugar Cravings	<input type="checkbox"/> Stress
<input type="checkbox"/> Weight Gain/Loss	<input type="checkbox"/> Cold Body Temp.	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Loss of Muscle Mass	<input type="checkbox"/> Thinning Skin	<input type="checkbox"/> Hair Loss
<input type="checkbox"/> Elevated Triglycerides	<input type="checkbox"/> Increased facial hair	<input type="checkbox"/> Low Libido
<input type="checkbox"/> Increased body hair	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Irritable
<input type="checkbox"/> Anxious	<input type="checkbox"/> Memory Lapse	<input type="checkbox"/> Acne
<input type="checkbox"/> Nervous		

Thyroid Deficiency

<input type="checkbox"/> Tired or Exhausted	<input type="checkbox"/> Difficult to Concentrate	<input type="checkbox"/> Nails Breaking/Brittle	<input type="checkbox"/> Infertility Problems
<input type="checkbox"/> Sad or Depressed	<input type="checkbox"/> Mood Changes	<input type="checkbox"/> Aches/Pains	<input type="checkbox"/> Slow Reflexes
<input type="checkbox"/> Cold Body Temp.	<input type="checkbox"/> Swelling/Puffy eyes/face	<input type="checkbox"/> Low Libido	<input type="checkbox"/> Constipation
<input type="checkbox"/> Cold Hands & Feet	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Thick Tongue
<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Slow Pulse Rate	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Slow Ankle Reflex
<input type="checkbox"/> Can't Lose Weight	<input type="checkbox"/> Decreased Sweating	<input type="checkbox"/> Bone Loss	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Memory Lapse	<input type="checkbox"/> Hair Dry/Brittle	<input type="checkbox"/> Decreased Muscle Mass	
<input type="checkbox"/> Forgetful	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Thinning Skin	