Healthy Nest nutrition

Hormone Questionnaire

Name_____Age:_____Date:_____

Please circle the appropriate answer "Yes or No" on all questions below.

(I realize there is some duplication with these questions. That is by design, to better assess how the problems you are having in each area.)

Part I-TD		
Has your muscle tone lessened?	YES	NO
Has your sex drive lessened?	YES	NO
Do you have decreased stamina and energy?	YES	NO
Do you have decreased armpit and body hair?	YES	NO
Do you have weakened bones or osteoporosis?	YES	NO
Part II-TE		
Do you have acne, or excessively oily skin?	YES	NO
Do you have a loss of head hair, or male pattern baldness?	YES	NO
Do you have excessive body hair?	YES	NO
Has your behavior become increasingly aggressive?	YES	NO
Has your voice deepened?	YES	NO
Part III-ED		
Are you experiencing hot flashes?	YES	NO
Are you experiencing night sweats?	YES	NO
Do you have mood swings?	YES	NO
Are you experiencing less mental clarity?	YES	NO
Do you have an increasingly poor memory?	YES	NO
Are you experiencing vaginal dryness?	YES	NO
Are you experiencing dry skin?	YES	NO
Do you have dry eyes?	YES	NO
Have you had any recent bladder infections?	YES	NO
Do you have urinary frequency or incontinence issues?	YES	NO
Are you experiencing headaches or migraines?	YES	NO
Are you having a decreased sexual response?	YES	NO
Part IV-EE		
Are you experiencing heavy bleeding?	YES	NO
Do you have clotting and cramping associated with your period?	YES	NO
Are your breasts tender?	YES	NO
Do you have cystic breasts?	YES	NO
Have you experienced recent weight gain?	YES	NO
Are you experiencing post menstrual headaches and migraines?	YES	NO
Do you have a decreased sexual response?	YES	NO
Have you noticed the development of any berry colored moles?	YES	NO
Have you experienced more irritability, anxiety or anger?	YES	NO
Is your mood down or depressed?	YES	NO

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Part V-PD		
Are you having a harder time with PMS symptoms?	YES	NO
Are you experiencing heavy bleeding?	YES	NO
Do you have spotting between periods?	YES	NO
Do you have clotting or cramping during periods?	YES	NO
Are you retaining water or bloating?	YES	NO
Have you experienced recent weight gain?	YES	NO
Are you experiencing headaches and migraines?	YES	NO
Is your mood down or depressed?	YES	NO
Are you having increased nervousness?	YES	NO
Have you experienced more irritability, or anxiety?	YES	NO
Do you have a problem with endometriosis or fibroids?	YES	NO
Are your breasts tender?	YES	NO
Do you have cystic breasts?	YES	NO
Are your periods infrequent?	YES	NO
Part VI-PE		
Are you increasingly sleepy or drowsy?	YES	NO
Are you experiencing constipation?	YES	NO
Are you bloated?	YES	NO
Is your mood down or depressed?	YES	NO
Part VII-Th		
Have you experienced recent weight gain?	YES	NO
Do you fatigue easily?	YES	NO
Are you experiencing ringing in your ears?	YES	NO
Are you sleepy during the day?	YES	NO
Are you sensitive to cold?	YES	NO
Do you have dry or scaly skin?	YES	NO
Are you experiencing constipation?	YES	NO
Do you feel you are mentally sluggish?	YES	NO
Is your hair coarse or falling out?	YES	NO
Do you have reduced initiative?	YES	NO
Do you have impaired hearing?	YES	NO
Do you have low blood pressure?	YES	NO
Are you experiencing increased frequency in urination?	YES	NO
Part VIII-AF		
Are you having difficulty getting up in the morning?	YES	NO
Do you have continuing fatigue, not relieved by sleep and rest?	YES	NO
Do your symptoms worsen if meals are skipped or inadequate?	YES	NO
Are you experiencing lethargy, or lack of energy to do normal daily activities?	YES	NO
Are your thoughts less focused?	YES	NO
Do you have sugar cravings?	YES	NO
Do you have salt cravings?	YES	NO
Do you have decreased tolerance for stress, noise or disorder?	YES	NO
Do you have allergies?	YES	NO
Do you have digestion problems?	YES	NO
Do you experience a low between 3:00 and 4:00 in the afternoon?	YES	NO
Do you feel like you don't really wake up until 10:00 am?	YES	NO

Part VIII-AF		
Do you get a "second wind" in the evening and stay up late?	YES	NO
Are you lightheaded or dizzy when you stand up quickly?	YES	NO
Are you feeling overwhelmed by all that needs to be done?	YES	NO
Do you have less enjoyment or happiness with life?	YES	NO
Part IX-L		
Are you increasingly sensitive to chemicals?	YES	NO
Is your cholesterol above 225?	YES	NO
Do you experience digestion discomfort?	YES	NO
Do you have chronic constipation?	YES	NO
Do you have extreme fatigue?	YES	NO
Do you have tender breasts?	YES	NO
Do you have heavy menstrual flow?	YES	NO
Are you experiencing pain in the right side of your abdomen?	YES	NO
Do you have skin eruptions like acne, psoriasis, or moles that are growing?	YES	NO
Do you have an increased susceptibility to infection?	YES	NO
Do your nails peel or break?	YES	NO