

The Hormone Balance Test

Patient Name: _____ **Date:** _____

Instructions: Check each symptom that applies to you. Please complete to the best of your knowledge.

Symptom Group 1

- PMS
- Insomnia
- Early miscarriage
- Painful or lumpy breasts
- Unexplained weight gain
- Cyclical headaches
- Anxiety
- Infertility

Total Checked **Group 1**

Symptom Group 2

- Vaginal dryness
- Night sweats
- Painful intercourse
- Memory problems
- Bladder infections
- Lethargic depression
- Hot flashes

Total Checked **Group 2**

Symptom Group 3

<input type="checkbox"/> Puffiness and bloating	<input type="checkbox"/> Migraine headaches
<input type="checkbox"/> Cervical dysplasia (abnormal pap smear)	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Rapid weight gain	<input type="checkbox"/> Foggy thinking
<input type="checkbox"/> Breast tenderness	<input type="checkbox"/> Red flush on face
<input type="checkbox"/> Mood swings	<input type="checkbox"/> Gallbladder problems
<input type="checkbox"/> Anxious depression	<input type="checkbox"/> Weepiness

Total Checked **Group 3**

Symptom Group 4

This group is a combination of the symptoms in groups 1 and 3. If you've checked two or more in each of these two groups, you may belong to this group.

Total Checked **Group 4**

Symptom Group 5

- Acne
- Polycystic ovary syndrome
- Excessive hair on face and arms
- Hypoglycemia and/or unstable blood sugar
- Thinning hair on head
- Infertility
- Ovarian cysts
- Midcycle pain

Total Checked **Group 5**

Symptom Group 6

- Debilitating fatigue
- Unstable blood sugar
- Foggy thinking
- Low blood pressure
- Thin and/or dry skin
- Intolerant to exercise
- Brown spots on face

Total Checked **Group 6**