



HORMONE SYMPTOM TRACKER

PLEASE CHECK YOUR CURRENT SYMPTOMS



NAME: _____

DATE: _____

ESTROGENS

- | | | |
|---|--|---|
| <input type="checkbox"/> HOT FLASHES | <input type="checkbox"/> DECREASED SENSUALITY | <input type="checkbox"/> VERTICAL LINES AROUND MOUTH |
| <input type="checkbox"/> NIGHT SWEATS | <input type="checkbox"/> PAIN DURING INTERCOURSE | <input type="checkbox"/> HIGH CHOLESTEROL BACK AND |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> URINARY LEAKAGE | <input type="checkbox"/> JOINT PAIN LOW BONE DENSITY* |
| <input type="checkbox"/> BRAIN FOG | <input type="checkbox"/> DROOPY BREASTS | <input type="checkbox"/> BREAST TENDERNESS BREAST |
| <input type="checkbox"/> FATIGUE/LOW ENERGY | <input type="checkbox"/> DRY, DEHYDRATED SKIN | <input type="checkbox"/> FULLNESS NIPPLE TENDERNESS |
| <input type="checkbox"/> WEIGHT GAIN | <input type="checkbox"/> THINNING SKIN | <input type="checkbox"/> FLUID RETENTION |
| <input type="checkbox"/> VAGINAL DRYNESS | <input type="checkbox"/> LOSS OF GLOW | <input type="checkbox"/> |
| <input type="checkbox"/> URINARY TRACT INFECTIONS | <input type="checkbox"/> DRY EYES* | <input type="checkbox"/> |

SIGNS OF EXCESS

PROGESTERONE

- | | | |
|--|---|---|
| <input type="checkbox"/> DIFFICULTY FALLING & STAYING ASLEEP | <input type="checkbox"/> BREAST LUMPS / FIBROCYSTIC BREASTS | <input type="checkbox"/> HISTORY OF INFERTILITY |
| <input type="checkbox"/> IRRITABILITY | <input type="checkbox"/> SWOLLEN FEET AND ANKLES | <input type="checkbox"/> HISTORY OF MISCARRIAGE |
| <input type="checkbox"/> ANXIOUS | <input type="checkbox"/> PERIOD IRREGULARITIES | <input type="checkbox"/> HEADACHES |
| <input type="checkbox"/> MOOD SWINGS | <input type="checkbox"/> SCANTY MENSTRUATION | <input type="checkbox"/> ACNE |
| <input type="checkbox"/> UNABLE TO RELAX | <input type="checkbox"/> HEAVY BLEEDING PMS | <input type="checkbox"/> SWOLLEN FACE |
| <input type="checkbox"/> HOT FLASHES | <input type="checkbox"/> FIBROIDS/ENDOMETRIOSIS | <input type="checkbox"/> LOW BONE DENSITY* |
| <input type="checkbox"/> SWOLLEN, PAINFUL BREASTS | | <input type="checkbox"/> DROWSINESS* |

SIGNS OF EXCESS

TESTOSTERONE / DHEA

- | | | |
|---|---|---|
| <input type="checkbox"/> LOSS OF MUSCLE | <input type="checkbox"/> DRY EYES | <input type="checkbox"/> UNWANTED HAIR GROWTH |
| <input type="checkbox"/> ABDOMINAL WEIGHT GAIN | <input type="checkbox"/> LOSS OF CONFIDENCE | <input type="checkbox"/> VOICE CHANGES |
| <input type="checkbox"/> CELLULITE | <input type="checkbox"/> LOW ENERGY/STAMINA | <input type="checkbox"/> AGGRESSION |
| <input type="checkbox"/> VARICOSE VEINS | <input type="checkbox"/> DIGESTIVE ISSUES | <input type="checkbox"/> OILINESS OF SKIN |
| <input type="checkbox"/> LOSS OF LIBIDO | <input type="checkbox"/> POOR TISSUE REPAIR | <input type="checkbox"/> HAIR LOSS ON HEAD |
| <input type="checkbox"/> LACK OF ORGASM | <input type="checkbox"/> IMMUNE DYSFUNCTION | <input type="checkbox"/> ACNE* |
| <input type="checkbox"/> LOW CLITORAL SENSITIVITY | <input type="checkbox"/> LOW BONE DENSITY* | |

SIGNS OF EXCESS

*MULTIPLE REASONS FOR THIS SYMPTOM