



Name:

Date:

<p style="text-align: center;"><u>Symptom Group 1</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> PMS <input type="checkbox"/> Early Miscarriage <input type="checkbox"/> Unexplained Weight Gain <input type="checkbox"/> Anxiety <input type="checkbox"/> Insomnia <input type="checkbox"/> Painful and/or Lumpy Breasts <input type="checkbox"/> Cyclical Headaches <input type="checkbox"/> Infertility 	<p style="text-align: center;"><u>Symptom Group 2</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Vaginal Dryness <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Bladder Infections <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Night Sweats <input type="checkbox"/> Memory Problems <input type="checkbox"/> Lethargic Depression
<p style="text-align: center;"><u>Symptom Group 3</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Puffiness and Bloating <input type="checkbox"/> Rapid Weight Gain <input type="checkbox"/> Mood Swings <input type="checkbox"/> Insomnia <input type="checkbox"/> Red Flush on Face <input type="checkbox"/> Weepiness <input type="checkbox"/> Cervical Dysplasia (Abnormal PAP Smear) <input type="checkbox"/> Breast Tenderness <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Foggy Thinking <input type="checkbox"/> Gallbladder Problems 	<p style="text-align: center;"><u>Symptom Group 4</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Acne <input type="checkbox"/> Excessive Hair on Face and Arms <input type="checkbox"/> Thinning Hair on the Head <input type="checkbox"/> Ovarian Cysts <input type="checkbox"/> Polycystic Ovary Syndrome <input type="checkbox"/> Hypoglycemia and/or Unstable Blood Pressures <input type="checkbox"/> Infertility <input type="checkbox"/> Mid-Cycle Pain
<p style="text-align: center;"><u>Symptom Group 5</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Debilitating Fatigue <input type="checkbox"/> Foggy Thinking <input type="checkbox"/> Thin and/or Dry Skin <input type="checkbox"/> Brown Spots on Face <input type="checkbox"/> Unstable Blood Sugar <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Intolerance to Exercise <input type="checkbox"/> "Crashing" in the Afternoon or Evening <input type="checkbox"/> Salt Cravings 	<p style="text-align: center;"><u>Symptom Group 6</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Feeling tired or sluggish <input type="checkbox"/> Feeling cold - hands, feet, all over <input type="checkbox"/> Require excessive amounts of sleep to function well <input type="checkbox"/> Weight gain despite adhering to a low-calorie diet <input type="checkbox"/> Difficult, infrequent bowel movements <input type="checkbox"/> Depression and lack of motivation <input type="checkbox"/> Morning headaches that wear off as the day progresses <input type="checkbox"/> Outer third of eyebrow thins <input type="checkbox"/> Thinning of hair on scalp, face, or genitals, or excessive hair loss <input type="checkbox"/> Dryness of skin and/or scalp <input type="checkbox"/> Mental sluggishness