

CHECKLIST FOR SYMPTOMS OF HORMONE IMBALANCE

FOR MEN

NAME _____ DATE _____

Basic Hormone Imbalance

Note which of the following symptoms are troublesome and/or persist over time.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Burned out feeling | <input type="checkbox"/> Irritable | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Decreased urine flow |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> Increased urinary urge | <input type="checkbox"/> Decreased stamina |
| <input type="checkbox"/> Weight gain waist | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Infertility problems | <input type="checkbox"/> Sleep disturbances |
| <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Decreased mental | <input type="checkbox"/> Oily skin | <input type="checkbox"/> Decreased muscle mass |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Sharpness | <input type="checkbox"/> Apathy | |

Number selected _____

Adrenal Hormone Imbalance

Note which of the following symptoms are troublesome and/or persist over time.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Aches and pains | <input type="checkbox"/> Elevated triglycerides | <input type="checkbox"/> Morning fatigue | <input type="checkbox"/> Bone loss |
| <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Blood sugar imbalance |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Allergic conditions | <input type="checkbox"/> Autoimmune illness |
| <input type="checkbox"/> Chronic illness | <input type="checkbox"/> Evening fatigue | <input type="checkbox"/> Susceptibility to infections | |

Number selected _____

Thyroid Hormone Imbalance

Note which of the following symptoms are troublesome and/or persist over time.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Brittle nails | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Cold hands and feet | <input type="checkbox"/> Headaches | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Foggy thinking | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Feeling cold all the time |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Low libido | <input type="checkbox"/> Inability to lose weight | <input type="checkbox"/> Sleep disturbances |
| <input type="checkbox"/> Thinning hair | <input type="checkbox"/> Menstrual irregularities | <input type="checkbox"/> Elevated cholesterol | <input type="checkbox"/> Thinning eyebrows |

Number selected _____