Naturally Unbridled Wellness

NUW Hormone Assessment Expanded

Name:_____ Date:_____

1 = Mild, 2 = Moderate, 3 = Severe, <u>BLANK</u> = does not apply

Section 1 (E) _____ Score

____ Hot flashes
____ Night sweats
____ Depression
____ Brain fog
____ Fatigue/low energy
____ Weight gain
____ Vaginal dryness
____ Urinary tract infections
____ Decreased Sensuality
____ Painful Intercourse
____ Urinary leakage
____ Droopy breasts
____ Dry, dehydrated skin
____ Thinning skin
____ Loss of glow
____ Dry eyes
____ Vertical lip lines
____ High cholesterol
____ Back & joint pain
____ Low bone density
____ Breast tenderness*
____ Breast fullness*
____ Nipple tenderness*
____ Fluid retention*

1 = Mild, 2 = Moderate, 3 = Severe, <u>BLANK</u> = does not apply

Section 2 (P) _____ Score

____ Poor sleep
____ Irritability
____ Anxious
____ Mood swings
____ Unable to relax
____ Swollen, painful breasts
____ Breast lumps/cysts
____ Swollen feet/ankles
____ Period irregularities
____Scanty menstruation
____ PMS
____ Fibroids/endometriosis
____ History of infertility
____ History of miscarriage
____ Headaches/migraines
____ Acne
____ Low bone density
____ Drowsiness*

Continued…

1 = Mild, 2 = Moderate, 3 = Severe, <u>BLANK</u> = does not apply

Section 3 (T) _____ Score

____ Loss of muscle	____ Dry eyes	____Unwanted hair growth*
____ Abdominal weight gain	____ Loss of confidence	____ Voice changes*
____ Cellulite	____ Low energy/stamina	____ Aggression*
____ Varicose veins	____ Digestive issues	____ Oily skin*
____ Low/no libido	____ Poor tissue repair	____ Thinning hair*
____ Lack of orgasm	____ Immune dysfunction	____ Acne*
____ Low clitoral sensitivity	____ Low bone density	____ Worse body odor*

1 = Mild, 2 = Moderate, 3 = Severe, <u>BLANK</u> = does not apply

Section 4 (I) _____ Score

____ Menstrual cycle longer than 28 days	____ Excess body hair on face, arms, chest, back, or buttocks
____ Cystic acne	____ Infertility
____ Weight-loss resistant	____ Mid-cycle/ovulation pain
____ Diagnosed PCOS	____ "Hangry"

Section 5 (M) _____ Score

Do you still have your uterus? YES ____ NO ____

How many ovaries do you have? ZERO ____ ONE ____ BOTH ____

When was your last menstrual period? _____

Average length of time from one period to the next? _____

Describe flow and cramping:

_____

_____

Continued…

1 = Mild, 2 = Moderate, 3 = Severe, <u>BLANK</u> = does not apply

Section 6 (CI) _____ Score

____ Known or suspected breast cancer or other estrogen or progesterone-sensitive cancer

____ Undiagnosed vaginal/genital bleeding

____ Active or recent artery or vein thromboembolic disease (blood clots)

____ Known or suspected pregnancy today

____ Active, severe liver disease or dysfunction

____ Known calcifications or hardening of the arteries

____ Currently smoke or vape

If you answered YES to any item in Section 5, please provide details below.

Hormone replacement therapy is not without risk. Consult your medical provider before adding hormones to your wellness plan.

Signature:_____ Date:_____