



OKULEY'S PHARMACY

Medical Equipment • Specialty Medications

CONSULTANT PHARMACIST AGREEMENT

For

New Patients Starting Natural Bio-Identical Hormone Replacement Therapy

Okuley's offers an ongoing consultation service for women and men who are receiving bio-identical natural hormone replacement therapy. A consulting fee of \$150.00 for up to a two hour consult will be charged to you when you start natural bio-identical hormone replacement therapy. This fee covers services you receive with our clinical pharmacists, including: initial work-up, research and consultation with you and your physician. You will be asked to make follow-up visits 1, 3, 6, and 12 months after starting your therapy. Each follow-up visit carries a fee of \$50.00 and lasts up to 30 minutes. Follow-up visits are needed to adjust therapies and ensure you are well balanced.

What can I expect?

- *We will work closely with your doctor to find the right therapy to meet your needs. It is important for you, as the patient, to communicate regularly with your physician about your goals. If your doctor needs more information about Bio-identical Hormone Replacement Therapy, we would be happy to provide it to him/her. The success of your therapy is greatly dependent upon a positive physician/pharmacist relationship.**
- *Unlike the commercial hormone replacement therapies with only a few strengths, Bio-identical hormones can be formulated in any dosage, and in a variety of forms to meet your personal needs.**
- *There will be an adjustment period of approximately three months, though the time frame may vary slightly from one person to the next. During this initial period, we will be in contact with you to discuss your symptoms and answer any questions you may have regarding your therapy. Successful hormone replacement therapy requires patience and consistent communication with your health care professionals.**

Lab Work

Levels of hormones can be helpful in evaluating your replacement needs. We suggest that you have your physician get base line levels of your hormones **before** starting human bio-identical hormone replacement.

Levels can be checked by either blood or saliva sample. If you prefer to have saliva testing, please contact the pharmacy for a saliva kit. Blood levels will have to be drawn at your physician's office.

The following labs are what we suggest you have drawn or collected:

Females:

If you are **still menstruating**: Sample **must be drawn or collected between days 18 and 21 of your cycle.** (Day 1 is the first day of your period.)

Estradiol

Progesterone

Pregnenolone (if you have memory problems)

Cortisol—(if under a lot of stress) a.m. Cortisol

DHEA-Sulfate (if under a lot of stress or low libido)

Testosterone (if low libido)

Thyroid (T4 total and free, T3 total and free, TSH, Vit D 25 OH Total, Ferritin)
(if tired, constipated, cold blooded, depressed, or experiencing weight gain)

If you are **no longer menstruating**: Sample can be drawn or collected any day of the month.

FSH

Estradiol

Progesterone

Pregnenolone (if you have memory problems)

Cortisol—(if under a lot of stress) a.m. Cortisol

DHEA-Sulfate (if under a lot of stress or low libido)

Testosterone (if low libido)

Thyroid (T4 total and free, T3 total and free, TSH, Vit D 25 OH Total, Ferritin)
(if tired, constipated, cold blooded, depressed or experiencing weight gain)

Lipid Panel



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Physician Medical Release Authorization

"I hereby authorize my Physician to furnish and agent of Okuley's Pharmacy and Home Medical any and all records pertaining to my medical history, services rendered and/or treatments. I understand that employees of Okuley's Pharmacy and Home Medical will protect my privacy and this information will be released to other health care professionals only when it is necessary in order to provide health care services to me. I further understand that an Okuley's Pharmacy and Home Medical employee will not release this information unless authorized by me in writing. This authority shall continue until revoked by me in writing."

Physician Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Patient Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Signature: _____

Patient Name:	SS#:
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General Medical History Form

Please return your form to the Pharmacy when you have finished.
The Pharmacist will meet with you to review your information. Thank you.

PATIENT INFORMATION:

TODAY'S DATE: _____

Name: _____

Birth Date: _____

Address: _____

Age: _____

City: _____

Phone: _____

Occupation: _____

Wk Phone: _____

Please provide your prescription insurance card before we fill your prescription

Living Situation: Spouse Alone Partner Friend(s) Parent Children Other

Status: Married Divorced Widowed

Blood Type: O A B AB

MEDICAL STATUS

How do you rate your general health? Excellent; Good; Fair Poor.

Height: _____ft._____in.; Weight: _____lbs

Blood pressure: _____ Pulse: _____

Lifestyle Information:		
	Do you use: Yes or No	If yes, how often and how much?
Tobacco (smoke, chew, dip)		
Alcohol (beer, wine, hard liquor)		
Caffeine (cola drinks, tea, coffee)		

IMPAIRMENTS: Check if you have any of the following:

_____ Physical impairment _____ Visual impairment _____ Hearing impairment

EXERCISE: Do you exercise regularly? YES NO

If YES, describe what you do and how often:

STRESS MANAGEMENT: Do you practice any stress management techniques?

YES NO If YES, describe what you do and how often.

SLEEP: How long does it take you to fall asleep? Minutes:

How many hours of sleep do you get per night? _____ hours

Do you sleep uninterrupted all night? YES NO

If NO, how many times do you awaken: _____ times. Do you awaken at a particular time(s)?

What awakens you? _____

Do you nap during the day? YES NO How often and how long do you nap?

DIET: Describe your typical daily food intake:

First Meal:

Second Meal:

Third Meal:

Any Snacks/Other:

DOCTOR INFORMATION: Are you currently under the care of a physician? YES NO

If YES, please list each doctor from whom you seek care, including address and phone number, if known:

Doctor Name: _____ Address: _____ Phone: _____

Doctor Name: _____ Address: _____ Phone: _____

Doctor Name: _____ Address: _____ Phone: _____

ALLERGIES: Please check all that apply:

_____ penicillin _____ morphine _____ dye allergies _____ pet allergies

Please describe the allergic reaction you experienced and when it occurred:

Please check all that apply to you, AND write the year you were diagnosed with each condition.

☐ Lung condition (ex. Asthma, Emphysema, COPD)
☐ Diabetes
☐ Arthritis or joint problems
☐ Depression
☐ Epilepsy
☐ Headaches/migraines
☐ Eye disease (glaucoma, etc.)
☐ Other. Please list:

[illegible]

OVER-THE-COUNTER (OTC) PRODUCTS:

Please check all products that you use.

- ___ Pain Reliever
 - ___ Acetaminophen (ex. Tylenol®)
 - ___ Ibuprofen (ex. Motrin IB®)
 - ___ Naproxen (ex. Aleve®)
 - ___ Ketoprofen (ex. Orudis KT®)
- ___ Cough Suppressant (ex. Robitussin DM®)
- ___ Antihistamine product (ex. Chlor-Trimeton®)
- ___ Decongestant product (ex. Sudafed®)
- ___ Combination product (cough & cold reliever)
(ex. Triaminic DM®)
- ___ Sleep aids (ex. Excedrin PM®, Unisom®,
Sominex®, Nytol®)

- ___ Antidiarrheals (ex. Imodium ®, Pepto Bismol®, Kaopectate ®)
- ___ Laxative/Stool Softeners (ex. Doxidan ®, Correctol ®, etc.)
- ___ Diet aids/Weight loss products (ex. Dexatrim ®)
- ___ Antacids (ex. Maalox ®, Mylanta ®)
- ___ Acid Blockers (ex. Tagament HB ®, Pepcid AC ®, Zantac 75 ®)
- ___ Other (please list):

**Please indicate how often you use each product that you checked above
(ie, every day, most days, occasionally or regularly).**

OTC Product	Taken How Often		OTC Product	Taken How Often

HERBAL SUPPLEMENTS, VITAMINS, AND OTHER NATURAL PRODUCTS:

[illegible]

FAMILY HISTORY:

Relative:

Disease:

TOP THREE BIGGEST CONCERNS / SYMPTOMS:

1. _____ Since When: _____
2. _____ Since When: _____
3. _____ Since When: _____

How did you arrive at the decision to consider Prescription Natural Hormone Replacement Therapy?

_____ Doctor _____ Self _____ Friend/Family member

Do you understand what Natural Hormone Replacement is?

How often are your bowel movements: _____/day OR _____/week. Do you suffer from frequent constipation, irritable bowel, colitis, and diarrhea or frequent bowel movements? Please give details:

Are you cold blooded? _____

FAMILY HISTORY: Do you have a family history of any of the following?

Disease:		Family Member(s):	
Uterine Cancer	_____	_____	_____
Ovarian Cancer	_____	_____	_____
Fibrocystic Breast	_____	_____	_____
Breast Cancer	_____	_____	_____
Heart Disease	_____	_____	_____
Osteoporosis	_____	_____	_____
Stroke	_____	_____	_____

Do you have a family history of any other conditions?

Relative:	Disease
_____	_____
_____	_____
_____	_____
_____	_____

GYNECOLOGICAL HISTORY:

Age your mother went into menopause: _____

Age at first period: _____ Date of last period: _____ Date of last mammogram: _____

Date of last pelvic exam: _____ and Pap smear: _____ Results: _____

Are you sexually active? Yes No

Are you trying to get pregnant? Yes No

Current birth control method: _____ How Long? _____

Problem with it: _____ How Long? _____

Past birth control and related problems: _____

Have you ever been on birth control? Yes No Brand: _____ How Long? _____

How many days from start of period to the start of the next: _____

Number of days of flow: _____ Amount of bleeding: _____

Amount of cramps: _____

Premenstrual symptoms: _____

Starting and ending when? _____

Any current changes in your normal cycle: _____

Any bleeding between periods: _____ When: _____

Any pelvic pain, pressure or fullness: _____ Describe: _____

SEXUAL (OPTIONAL)

Are you sexually active now: Y N If No, is that a problem for you? _____

If you were rating the sexual part of your life on a schedule of 1 to 10, where would you put it?

What would you change about it, if you could?

Do you have any problems with sexual

Desire? _____

Frequency? _____

Arousability? _____

Orgasm (Do you usually climax)? Y N If no, is that a problem for you? _____

Pain? Y N _____

Do you have any pain at the beginning of, during, or after having sex? _____

Are you experiencing vaginal dryness: Y N If Yes, when did you first notice it? _____

Have you experienced a loss of sexual sensitivity:

Of the nipples?

Of the clitoris?

Have you noticed any changes in your body hair patterns: _____

Have you lost any pubic Hair? If Yes, when did you first notice it? _____

Has your sex life changed significantly in the past few years?

If Yes, how? _____

Do you think there is anything your partner would like to change? _____

Is there anything you can think of that we have not covered and that may be important to your sexual life?

PRESCRIPTION HORMONE MEDICATIONS:

Current Hormone Replacement Therapy:

Name: _____

Strength/Dosage: _____

Date Started/Stopped (if applicable): _____

Previous Hormone Replacement Therapy:

Name: _____

Strength/Dosage: _____

Reason for Change: _____

Any unusual vaginal discharge or itching? _____ Describe: _____

Treatment: _____

Age at first pregnancy: _____ How many full term pregnancies? _____

Problems: _____

Any interrupted pregnancies: Miscarriages: Yes No Abortions: Yes No

Which pregnancy? _____

Have you had a tubal ligation? Yes No When? _____ Cycle or symptoms change after? _____

Have you had a hysterectomy? Yes No When? _____ Symptoms Change After? _____

Have you had any part or whole ovary removed? Yes No When? _____

Cycle or symptoms change after? _____

QUESTION DOCUMENTATION FORM

Please write down any questions you may have about Prescription Bio-Identical Hormone Replacement Therapy (RxBHRT), other medications, or any other questions that come up as you read through the materials you have received. Bring this question sheet with you to your consultation so you can discuss this information with your pharmacist/nurse. Thank you.

1.

2.

3.

4.

5.

--

Hormone Replacement Therapy Patient Symptoms Sheet

Rate your current status for each symptom by clicking the box to the left of each number (or circling the appropriate number if filling out on paper). Please feel free to use the text boxes at the bottom of the page to describe any symptom. This section may be repeated on subsequent visits.

	Mild	Moderate	Severe
Headaches	1	3	5
Anxiety	1	3	5
Moodiness	1	3	5
Depression	1	3	5
Irritability	1	3	5
Emotional Swings	1	3	5
Insomnia	1	3	5
Swollen Breasts	1	3	5
Painful Breasts	1	3	5
Fibrocystic Breasts	1	3	5
Fuzzy Thinking	1	3	5
Short-term Memory Loss	1	3	5
Food Cravings (salty or sweet)	1	3	5
Weight Gain	1	3	5
Bloating	1	3	5
Water Retention	1	3	5
Hot Flashes	1	3	5
Night Sweats	1	3	5

Comments:

Continued on back of page

Shortness of Breath	1	3	5
Low Libido	1	3	5
Inability to Reach Orgasm	1	3	5
Vaginal Dryness	1	3	5
Painful Intercourse	1	3	5
Vaginal Shrinkage	1	3	5
Dry Hair/Skin	1	3	5
Hair Loss	1	3	5
Loss of Pubic Hair	1	3	5
Frequent Urinary Tract Infections	1	3	5
Frequent Yeast Infections	1	3	5
Heart Palpitations	1	3	5
Fatigue, Lack of Energy	1	3	5
Pre-Menstrual Mood Swings	1	3	5
Heavy or Irregular Menses	1	3	5
Cramps	1	3	5
Uterine Fibroids	1	3	5
Bladder Symptoms	1	3	5
Symptoms of Low Thyroid (decreased metabolism)	1	3	5
Symptoms of Low Sugar (Shakiness, lightheadedness before next meal)	1	3	5

Comments:

Thyroid Symptom Assessment

Please check all symptoms that apply:

- | | |
|--|---|
| ☐ Fatigue (especially in evening) | ☐ Heat Intolerance |
| ☐ Dry, Coarse, or Itchy Skin | ☐ Irritability |
| ☐ Scalp Hair Loss | ☐ Moist Skin |
| ☐ Dry, Coarse, or Thinning Hair | ☐ Increased Sweating |
| ☐ Memory Lapses | ☐ Diarrhea |
| ☐ Thinning Eyebrows | ☐ Tremors |
| ☐ Headaches | ☐ Nervousness |
| ☐ Anxiety | ☐ Brittle Hair |
| ☐ Poor Concentration | ☐ Thinning of Skin |
| ☐ Fibromyalgia | ☐ Trouble Sleeping |
| ☐ Cold Feeling in Extremities | |
| ☐ General Aches and Pains | |
| ☐ Brittle Nails | |
| ☐ Heart Palpitations | |
| ☐ Low Stamina | |
| ☐ Cold Intolerance | |
| ☐ Swollen or Puffy Eyes | |
| ☐ High Cholesterol | |
| ☐ Upper Eyelid Drop | |
| ☐ Low Libido | |
| ☐ Depression | |
| ☐ Low Heart Rate/Blood Pressure | |
| ☐ Constipation | |
| ☐ Low Body Temperature | |
| ☐ Weight Gain | |
| ☐ Increased Swelling | |
| ☐ Infertility | |

ADRENAL QUESTIONNAIRE

If you answer yes to 3 or more questions, you may have some degree of adrenal burnout. Check the line if yes:

- _____ Are you tired for “no reason”?
- _____ Do you have trouble getting up in the morning?
- _____ Do you need coffee or colas to keep you going?
- _____ Do you feel run down and stressed?
- _____ Do you crave salty or sweet snacks?
- _____ Are you struggling to keep up with life’s daily demands?
- _____ Can you not bounce back from stress or illness?
- _____ Are you not having fun anymore?
- _____ Is your sex drive decreased?
- _____ Do you have difficulty falling/staying asleep or do you have trouble shutting your mind off at night?
- _____ Do you have vivid nightmares or dreams?
- _____ Do you have low blood pressure (lower than 110 on the top and lower than 70 on the bottom)?
- _____ Do you feel as if you could take a nap an hour or so after lunch?
- _____ Do you eat at least one processed or sweetened food at each meal or frequently skip meals?
- _____ Are your pupils normally dilated even during the day?
- _____ Do you seem to get sick or suffer from allergies more frequently than you used to?
- _____ Do you feel pressured or rushed often during the day?
- _____ Do you experience lightheadedness, mood swings or headaches if you go more than 4-6 hours between meals?

MEMORY QUESTIONNAIRE

Over the last year, I have experienced:

_____ Becoming forgetful

_____ Lapses in memory

_____ Becoming less attentive

_____ Less interest in normal activities

_____ Feeling less sharp

_____ Difficulty remembering people's names

_____ Difficulty making decisions

_____ Problems finding the right words to communicate

_____ Difficulty solving routine problems

_____ Difficulty learning new things

_____ Problems writing, reading, or organizing thoughts

_____ Difficulty following instructions

Amino Acid Deficiency Symptoms

Instructions: Mark the box or boxes that identify your corresponding symptoms.

L-glutamine

- ☐ Cravings for sugar, starch, or alcohol
- ☐ Reduced mental stability

L-tyrosine, L-phenylalanine

- ☐ Depression
- ☐ Lack of energy
- ☐ Lack of drive
- ☐ Lack of focus, concentration

GABA

- ☐ Stiff and tense muscles
- ☐ Stressed
- ☐ Feeling “burned out”
- ☐ Unable to relax

DL-phenylalanine, D-phenylalanine

- ☐ Very sensitive to emotional or physical pain
- ☐ Cry easily
- ☐ Crave comfort, reward, or numbing treats
- ☐ “Love” certain foods or drugs

L-tryptophan, 5-HTP (serotonin), Melatonin (sleep)

- ☐ Depression, Negativity
- ☐ Worry, anxiety
- ☐ Low self-esteem
- ☐ Obsessive thoughts/behaviors
- ☐ The “winter blues”
- ☐ PMS
- ☐ Irritability, rage
- ☐ Heat intolerance
- ☐ Panic, phobias
- ☐ Afternoon or evening cravings
- ☐ Fibromyalgia, TMJ
- ☐ Sleep disturbances – hard time getting to sleep, or staying asleep
- ☐ Suicidal thoughts

Do you crave any of the following to compensate for the above symptoms? (check to left)

sweets, starches, alcohol, chocolate, caffeine, tobacco, marijuana, cocaine, heroin

HEALTH APPRAISAL QUESTIONNAIRE

Name _____ Date _____

DIRECTIONS

This questionnaire asks you to assess how you have been feeling **during the last four months**. This information will help you keep track of how your physical, mental and emotional states respond to changes you make in your eating habits, priorities, supplement program, social and family life, level of physical activity and time spent on personal growth. All information is held in strict confidence. Take all the time you need to complete this questionnaire.

For each question, circle the number that best describes your symptoms:

0 = No or Rarely—You have never experienced the symptom or the symptom is familiar to you but you perceive it as insignificant (monthly or less)

1 = Occasionally—Symptom comes and goes and is linked in your mind to stress, diet, fatigue or some identifiable trigger

4 = Often—Symptom occurs 2-3 times per week and/or with a frequency that bothers you enough that you would like to do something about it

8 = Frequently—Symptom occurs 4 or more times per week and/or you are aware of the symptom every day, or it occurs with regularity on a monthly or cyclical basis

Some questions require a YES or NO response: 0 = NO 8 = YES

PART I

SECTION A

- | | No/Rarely | Occasionally | Often | Frequently |
|--|-----------|--------------|-------|------------|
| 1. Indigestion, food repeats on you after you eat | | | | |
| 2. Excessive burping, belching and/or bloating following meals | | | | |
| 3. Stomach spasms and cramping during or after eating | | | | |
| 4. A sensation that food just sits in your stomach creating uncomfortable fullness, pressure and bloating during or after a meal | | | | |
| 5. Bad taste in your mouth | | | | |
| 6. Small amounts of food fill you up immediately | | | | |
| 7. Skip meals or eat erratically because you have no appetite | | | | |

Total points _____

SECTION B

- | | No/Rarely | Occasionally | Often | Frequently |
|--|-----------|--------------|-------|------------|
| 1. Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt | | | | |
| 2. Feel hungry an hour or two after eating a good-sized meal | | | | |
| 3. Stomach pain, burning and/or aching over a period of 1-4 hours after eating | | | | |
| 4. Stomach pain, burning and/or aching relieved by eating food; drinking carbonated beverages, cream or milk; or taking antacids | | | | |
| 5. Burning sensation in the lower part of your chest, especially when lying down or bending forward | | | | |
| 6. Digestive problems that subside with rest and relaxation | | | | |
| 7. Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache | | | | |
| 8. Feel a sense of nausea when you eat | | | | |
| 9. Difficulty or pain when swallowing food or beverage | | | | |

Total points _____

SECTION C

- | | No/Rarely | Occasionally | Often | Frequently |
|--|-----------|--------------|-------|------------|
| 1. When massaging under your rib cage <i>on your left side</i> , there is pain, tenderness or soreness | | | | |
| 2. Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal | | | | |
| 3. Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement | | | | |
| 4. Specific foods/beverages aggravate indigestion | | | | |
| 5. The consistency or form of your stool changes (e.g., from narrow to loose) within the course of a day | | | | |

No/Rarely
Occasionally
Often
Frequently

SECTION C (cont.)

- | | No/Rarely | Occasionally | Often | Frequently |
|---|-----------|--------------|-------|------------|
| 6. Stool odor is embarrassing | | | | |
| 7. Undigested food in your stool | | | | |
| 8. Three or more large bowel movements daily | | | | |
| 9. Diarrhea (frequent loose, watery stool) | | | | |
| 10. Bowel movement shortly after eating (within 1 hour) | | | | |

Total points _____

SECTION D

- | | No/Rarely | Occasionally | Often | Frequently |
|--|-----------|--------------|-------|------------|
| 1. Discomfort, pain or cramps in your colon (lower abdominal area) | | | | |
| 2. Emotional stress and/or eating raw fruits and vegetables causes abdominal bloating, pain, cramps or gas | | | | |
| 3. Generally constipated (or straining during bowel movements) | | | | |
| 4. Stool is small, hard and dry | | | | |
| 5. Pass mucus in your stool | | | | |
| 6. Alternate between constipation and diarrhea | | | | |
| 7. Rectal pain, itching or cramping | | | | |
| 8. No urge to have a bowel movement | | | | |
| 9. An almost continual need to have a bowel movement | | | | |

Total points _____

PART II

- | | No/Rarely | Occasionally | Often | Frequently |
|---|-----------|--------------|-------|------------|
| 1. When massaging under your rib cage <i>on your right side</i> , there is pain, tenderness or soreness | | | | |
| 2. Abdominal pain worsens with deep breathing | | | | |
| 3. Pain at night that may move to your back or right shoulder | | | | |
| 4. Bitter fluid repeats after eating | | | | |
| 5. Feel abdominal discomfort or nausea when eating rich, fatty or fried foods | | | | |
| 6. Throbbing temples and/or dull pain in forehead associated with overeating | | | | |
| 7. Unexplained itchy skin that's worse at night | | | | |
| 8. Stool color alternates from clay colored to normal brown | | | | |
| 9. General feeling of poor health | | | | |

PART II

- | | No/Rarely | Occasionally | Often | Frequently |
|---|-----------|--------------|-------|------------|
| 10. Aching muscles not due to exercise | | | | |
| 11. Retain fluid and feel swollen around the abdominal area | | | | |
| 12. Reddened skin, especially palms | | | | |
| 13. Very strong body odor | | | | |
| 14. Are you embarrassed by your breath? | | | | |
| 15. Bruise easily | | | | |
| 16. Yellowish cast to eyes | | | | |

Total points**PART III****SECTION A**

- | | No/Rarely | Occasionally | Often | Frequently |
|---|-----------|--------------|-------|------------|
| 1. Feel cold or chilled—hands, feet or all over—for no apparent reason | | | | |
| 2. Your upper eyelids look swollen | | | | |
| 3. Muscles are weak, cramp and/or tremble | | | | |
| 4. Are you forgetful? | | | | |
| 5. Do you feel like your heart beats slowly? | | | | |
| 6. Reaction time seems slowed down | | | | |
| 7. In general, are you disinterested in sex because your desire is low? | | | | |
| 8. Feel slow-moving, sluggish | | | | |
| 9. Constipation | | | | |
| 10. Dryness, discoloration of skin and/or hair | | | | |
| 11. Have you noticed recently that your voice is deepening? | | | | |
| 12. Thick, brittle nails | | | | |
| 13. Weight gain for no apparent reason | | | | |
| 14. Outer third of your eyebrow is thinning or disappearing | | | | |
| 15. Swelling of the neck | | | | |

Total points**SECTION B**

- | | No/Rarely | Occasionally | Often | Frequently |
|---|-----------|--------------|-------|------------|
| 1. Lingering mild fatigue after exertion or stress | | | | |
| 2. Do you find that you get tired and exhaust easily? | | | | |
| 3. Craving for salty foods | | | | |
| 4. Sensitive to minor changes in weather and surroundings | | | | |
| 5. Dizzy when rising or standing up from a kneeling position | | | | |
| 6. Dark bluish or black circles under your eyes | | | | |
| 7. Have bouts of nausea with or without vomiting | | | | |
| 8. Catch colds or infections easily | | | | |
| 9. Wounds heal slowly | | | | |
| 10. Your body or parts of your body feel tender, sore, sensitive to the touch, hot and/or painful | | | | |
| 11. Feel puffy and swollen all over your body | | | | |
| 12. Skin is gradually tanning without exposure to sun or the ingestion of high levels of carotene-rich foods (e.g., daily carrot juice intake) or supplements | | | | |

Total points**PART IV****SECTION A**

When you miss meals or go without food for extended periods of time, do you experience any of the following symptoms?

- | | No/Rarely | Occasionally | Often | Frequently |
|---|-----------|--------------|-------|------------|
| 1. A sense of weakness | | | | |
| 2. A sudden sense of anxiety when you get hungry | | | | |
| 3. Tingling sensation in your hands | | | | |
| 4. A sensation of your heart beating too quickly or forcefully | | | | |
| 5. Shaky, jittery, hands trembling | | | | |
| 6. Sudden profuse sweating and/or your skin feels clammy | | | | |
| 7. Nightmares possibly associated with going to bed on an empty stomach | | | | |
| 8. Wake up at night feeling restless | | | | |
| 9. Agitation, easily upset, nervous | | | | |
| 10. Poor memory, forgetful | | | | |
| 11. Confused or disoriented | | | | |
| 12. Dizzy, faint | | | | |
| 13. Cold or numb | | | | |
| 14. Mild headaches or head pounding | | | | |
| 15. Blurred vision or double vision | | | | |
| 16. Feel clumsy and uncoordinated | | | | |

16

Total points**SECTION B**

- | | No/Rarely | Occasionally | Often | Frequently |
|---|-----------|--------------|-------|------------|
| 1. Frequent urination during the day and night | | | | |
| 2. Unusual thirst—feeling like you can't drink enough water | | | | |
| 3. Unusual hunger—eating all the time | | | | |
| 4. Vision blurs | | | | |
| 5. Feel itchy all over | | | | |
| 6. Tingling or numbness in your feet | | | | |
| 7. Sense of drowsiness, lethargy during the day not associated with missing meals or not sleeping | | | | |
| 8. Eating starchy foods, even if they are healthy and unprocessed (like rice, corn, beans, whole wheat or oats), causes you to gain weight or prevents you from losing weight | | | | |
| 9. Sores heal slowly | | | | |
| 10. Loss of hair on your legs | | | | |

Total points**PART V****SECTION A**

- | | No/Rarely | Occasionally | Often | Frequently |
|---|-----------|--------------|-------|------------|
| 1. Feel jittery | | | | |
| 2. First effort of the day causes pain, pressure, tightness or heaviness around the chest | | | | |
| 3. Exhaustion with minor exertion | | | | |
| 4. Heavy sweating (no exertion, no hot flashes) | | | | |
| 5. Difficulty catching breath, especially during exercise | | | | |
| 6. Heart pounding, sensation of heart beating too quickly, too slowly or irregularly | | | | |
| 7. Swelling in feet, ankles and/or legs comes and goes for no apparent reason | | | | |

Total points

PART V (cont.)

No/Rarely
Occasionally
Often
Frequently

SECTION B

1. Muscle pain at rest
2. Cramp-like pains in your ankles, calves or legs
3. Numbness, tingling and prickling sensation in hands and feet
4. Cold feet and/or toes appear blue
5. Brief moments of hearing loss
6. Nausea comes and goes quickly (unrelated to eating)
7. Feel worse standing: legs get heavy and fatigued
8. Leg discomfort or fatigue relieved by elevating legs
9. Fingers and toes get numb in cold weather even when protected
10. Notice changes in your ability to feel pain or differentiate between sensations of hot or cold
11. Body hair (on arms, hands, fingers, legs and toes) is thinning or has disappeared
12. Do you notice a decline in your ability to make decisions, concentrate, focus attention or follow directions?

Total points

PART VI

SECTION A

1. Family, friends, work, hobbies or activities you hold dear are no longer of interest
2. Do you cry?
3. Does life look entirely hopeless?
4. Would you describe yourself as feeling miserable and sad, unhappy or blue?
5. Do you find it hard to make the best of difficult situations?
6. Sleep problems—too much or too little sleep
7. Changes in your appetite and weight
8. Lately you've noticed an inability to think clearly or concentrate
9. Difficulty making decisions and/or clarifying and achieving your goals

Total points

SECTION B

1. Does worrying get you down?
2. Does every little thing get on your nerves and wear you out?
3. Would you consider yourself a nervous person?
4. Do you feel easily agitated?
5. Do you shake and tremble?
6. Are you keyed up and jittery?
7. Do you tremble or feel weak when someone shouts at you?
8. Do you become scared at sudden movements or noises at night?
9. Do you find yourself sighing a lot?
10. Are you awakened out of your sleep by frightening dreams?
11. Do frightening thoughts keep coming back in your mind?

No/Rarely
Occasionally
Often
Frequently

SECTION B (cont.)

12. Do you become suddenly scared for no reason?
13. Do you break out in a cold sweat?
14. "Butterflies in your stomach," nausea and/or diarrhea

Total points

SECTION C

1. Do you feel pent up and ready to explode?
2. Are you prone to noisy and emotional outbursts?
3. Do you do things on impulse?
4. Are you easily upset or irritated?
5. Do you go to pieces if you don't control yourself?
6. Do little annoyances get on your nerves and make you angry?
7. Does it make you angry to have anyone tell you what to do?
8. Do you flare up in anger if you can't have what you want right away?

Total points

PART VII

1. Eyes water or tear
2. Mucus discharge from the eyes
3. Ears ache, itch, feel congested or sore
4. Discharge from ears
5. Is your nose continually congested?
6. Are you prone to loud snoring?
7. Does your nose run?
8. Nosebleeds
9. Hoarse voice
10. Do you have to clear your throat?
11. Do you feel a choking lump in your throat?
12. Do you suffer from severe colds?
13. Do frequent colds keep you miserable all winter?
14. Flu symptoms last longer than 5 days
15. Do infections settle in your lungs?
16. Chest discomfort or pain
17. Do you experience sudden breathing difficulties?
18. Do you struggle with shortness of breath?
19. Difficulty exhaling (breathing out)
20. Breathlessness followed by coughing during exertion, no matter how slight
21. Inability to breathe comfortably while lying down
22. Do you cough up lots of phlegm?
23. Can you hear noisy rattling sounds when breathing in and out?
24. Are you troubled with coughing?
25. Do you wheeze?
26. Do you have severe soaking sweats at night?
27. Do your lips and/or nails have a bluish hue?
28. Are you sleepy during the day?

28

PART VII (cont.)

No/Rarely
Occasionally
Often
Frequently

29. Do you have difficulty concentrating?
30. Eyes, ears, nose, throat and lung symptoms seem associated with specific foods like dairy or wheat products
31. Eyes, ears, nose, throat and lung symptoms are associated with seasonal changes

Total points

PART VIII

1. Involuntary loss of urine when you cough, lift something or strain during an activity
2. Mild lower back ache or pain
3. Abdominal achiness or pain
4. Pain or burning when urinating
5. Rarely feel the urge to urinate
6. Feel the need to urinate less than every two hours during the day or night
7. Strong smelling urine
8. Back or leg pains are associated with dripping after urination
9. Sore or painful genitals
10. Urine is a rose color
11. Sudden urge to void causes involuntary loss of urine
12. Generalized sense of water retention throughout your body

Total points

PART IX**SECTION A**

1. Bones throughout your entire body ache, feel tender or sore
2. Localized bone pain
3. Hands, feet or throat get tight, spasm or feel numb
4. Difficulty sitting straight
5. Upper back pain
6. Lower back pain
7. Pain when sitting down or walking
8. Find yourself limping or favoring one leg
9. Shins hurt during or after exercise

Total points

SECTION B

1. Are you stiff in the morning when you wake up?
2. Difficulty bending down and picking up clothing or anything from the floor
3. Joint swelling, pain or stiffness involving one or more areas (fingers, hands, wrists, elbows, shoulders, toes, arches, feet, ankles, knees or ankles)
4. Joints hurt when moving or when carrying weight
5. A routine exercise program, like daily walking, causes your knees to swell or hurt
6. Difficulty opening jars that were previously easy to open
7. Discomfort, numbness, prickling or tingling sensation, or pain in neck, shoulder or arm

SECTION B (cont.)

8. Intermittent pain or ache on one side of head spreading to cheek, temple, lower jaw, ear, neck and shoulder
9. Difficulty chewing food or opening mouth
10. Difficulty standing up from a sitting position
11. Shooting, aching, tingling pain down the back of leg
12. Is it difficult to reach up and get a 5-pound object like a bag of flour from just above your head?
13. Injure, strain or sprain easily

Total points

SECTION C

1. Muscles stiff, sore, tense and/or achy
2. Burning, throbbing, shooting or stabbing muscle pain
3. Muscle cramps or spasms (involuntary or after exertion/exercise)
4. Is muscle pain or stiffness greater in the morning than other times of the day?
5. Specific points on body feel sore when pressed
6. Feel unrefreshed upon awakening
7. Headaches
8. Pain at the sides of your head or in your face especially when awakening
9. Your jaw clicks or pops
10. Muscle twitch or tremor—eyelids, thumb, calf muscle
11. Irresistible urge to move legs
12. Legs move during sleep
13. Unpleasant crawling sensation inside calves when lying down
14. Hand and wrist numbness or pain (e.g., interferes with writing or with buttoning or unbuttoning your clothes)
15. Feeling of "pins and needles" in your thumb and first three fingers
16. Pain in forearm and sometimes in shoulder

Total points

PART X**SECTION A**

1. Head feels heavy
2. Dizziness
3. Difficulty bending over, standing up from sitting, rolling over in bed and/or turning your head from side to side
4. Your hands tremble, ever so slightly, for no apparent reason
5. You feel like you're wearing heavy weights on your feet when walking
6. Bump into things, trip, stumble and feel clumsy
7. Difficulty breathing
8. Difficulty swallowing
9. People tell you to speak up because they have trouble hearing you
10. Speaking and forming words does not feel automatic
11. Need 10-12 hours of sleep to feel rested

PART X (cont.)

No/Rarely
Occasionally
Often
Frequently

SECTION A (cont.)

12. Lack strength (your grip is weak, holding your head or picking your arms up takes effort)
13. Hands get tired when you write and your handwriting is less legible and smaller than it used to be
14. Muscles in arms and legs seem softer and smaller
15. Is your eyesight, sense of smell and taste or ability to hear not as sharp as it used to be?
16. Do you find yourself moving slower than you used to?

Total points**SECTION B**

1. Difficulty absorbing new information
2. Tend to forget things
3. Trouble thinking or concentrating
4. Easily distracted
5. Do you have a tendency to become frustrated quickly?
6. Inability to sit still for any length of time, even at mealtime
7. Finishing tasks is easier said than done
8. Do you have more trouble solving problems or managing your time than usual?
9. Low tolerance for stress and otherwise ordinary problems

Total points**PART XI****Men Only**

1. Sensation of not emptying your bladder completely
2. Need to urinate less than 2 hours after you have finished urinating
3. Find yourself needing to stop and start again several times while urinating
4. Find it difficult to postpone urination
5. Have a weak urinary stream
6. Need to push or strain to begin urinating
7. Dripping after urination
8. Urge to urinate several times a night

Total points**PART XII****Women Only***(Menopausal women should skip to Sections E and F)***SECTION A****Do you persistently experience any of these symptoms within three days to two weeks *prior to menstruation*?****[A]**

1. Anxious, irritable or restless
2. Numbness, tingling in hands and feet
3. Easy to anger, resentful
4. Aggressive or hostile toward family/friends

No/Rarely
Occasionally
Often
Frequently

SECTION A (cont.)**[B]**

5. Abdominal bloating, feeling swollen (e.g., feet)
6. Temporary weight gain
7. Breast tenderness, swelling
8. Appearance of breast lumps
9. Discharge from nipples
10. Nausea and/or vomiting
11. Diarrhea or constipation
12. Aches and pains (back, joints, etc.)

[C]

13. Craving for sweets
14. Increased appetite or binge eating
15. Headaches
16. Being easily overwhelmed, shaky or clumsy
17. Heart pounding
18. Dizziness or fainting

[D]

19. Confused and forgetful to the point that work suffers
20. Overwhelmed with feelings of sadness and worthlessness
21. Difficulty sleeping or falling asleep
22. Engaging in self-destructive behavior

Total points**SECTION B****Do you experience any of these symptoms *during your period*?**

1. Cramping in lower abdomen or pelvic area
2. Lower abdominal pain is sharp and/or dull or intermittent
3. Bloating and sense of abdominal fullness
4. Diarrhea or constipation
5. Nausea and/or vomiting
6. Low back and/or legs ache
7. Headaches
8. Unusual fatigue (take naps) resulting in missed work
9. Painful and/or swollen breasts
10. Scanty blood flow

Total points**SECTION C**

1. Painful or difficult sexual intercourse 1
2. Low abdominal, back and vaginal pain throughout the month
3. Pelvic pressure or pain while sitting down or standing up, relieved by lying down
4. Vaginal bleeding other than during your period 5
5. Painful bowel movements
6. Difficult (straining) urination
7. Abnormal vaginal discharge
8. Offensive vaginal discharge
9. Vaginal itching or burning with or without intercourse
10. Pain during periods is getting progressively worse 10
11. Profuse or prolonged menstrual bleeding
12. Unable to get pregnant

12

Total points

PART XII (cont.)

No/Rarely
Occasionally
Often
Frequently

SECTION D

1. Absence of periods for six months or longer 1
2. Periods occur irregularly (e.g., 3 to 6 times a year)
3. Profuse heavy bleeding during periods
4. Menstrual blood contains clots and tissue
5. Bleeding between periods can occur anytime 5
6. Periods occur greater than every 35 days
7. Intense upper stomach pain, lasting several hours at the time you ovulate (approximately day 14 of your cycle)
8. Bleeding occurs at ovulation (approximately day 14 of your cycle)
9. Monthly abdominal pain without bleeding 10
10. Abundant cervical mucus
11. Acne and/or oily skin
12. Overwhelming urges for sexual intercourse
13. Aggressive feelings
14. Increased growth of dark facial and/or body hair
15. Poor sense of smell 15
16. Voice is becoming deeper
17. Breasts seem to be getting smaller
18. Receding hairline

Total points

SECTION E

1. Vaginal discharge
2. Vaginal secretions are watery and thin
3. Vaginal dryness
4. Sexual intercourse is uncomfortable

No/Rarely
Occasionally
Often
Frequently

SECTION E (cont.)

5. Interest in having sex is low
6. Engorged breasts
7. Breast tenderness, soreness
8. Difficulty with orgasm
9. Vaginal bleeding after sexual intercourse
10. Do you skip periods?
11. The length (number of days) of your period varies month to month, with the number of days of bleeding getting fewer

Total points

SECTION F

1. Sense of well-being fluctuates throughout the day for no apparent reason
2. Sudden hot flashes
3. Spontaneous sweating
4. Chills
5. Cold hands and feet
6. Heart beats rapidly or feels like it is fluttering
7. Numbness, tingling or prickling sensations
8. Dizziness
9. Mental fogginess, forgetful or distracted
10. Inability to concentrate
11. Depression, anxiety, nervousness and/or irritability
12. Difficulty sleeping
13. Conscious of new feelings of anger and frustration
14. Skin, hair, vagina and/or eyes feel dry
15. Stopped menstruating around six months ago, yet still experience some vaginal bleeding

Total points

Please mark an "X" to indicate areas where you feel pain, swelling or discomfort, or areas of your skin that have changed color or texture (e.g., moles, rashes, etc.). Describe what you feel or observe in your own words. Write anywhere in this area.

