

## Messenger of Health

### Male/Female Questionnaire for Hormone Balancing

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Please Check if you suffer any of the following:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Aches/Pains            | <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Migraines       |
| <input type="checkbox"/> Anxiety                | <input type="checkbox"/> Depression       | <input type="checkbox"/> Memory Problems |
| <input type="checkbox"/> Addictive Behavior     | <input type="checkbox"/> Irritable Bowel  | <input type="checkbox"/> Mood Swings     |
| <input type="checkbox"/> Decreased Bone Density | <input type="checkbox"/> Hot Flashes      | <input type="checkbox"/> Sleep Issues    |

Medical History: Do you or a family member have or had any of the following:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Cancer                      | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Overactive Bladder |
| <input type="checkbox"/> Diabetes/Insulin Resistance | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Poor Digestion     |
| <input type="checkbox"/> Frequent Urination          | <input type="checkbox"/> Allergies/Asthma    | <input type="checkbox"/> Thyroid Disorder   |

Please list any diseases or conditions you have been diagnosed with: \_\_\_\_\_

Please list all surgeries you have had or scheduled for: \_\_\_\_\_

\_\_\_\_\_

Please list any medications you are on: \_\_\_\_\_

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Do you regularly consume caffeine daily? \_\_\_\_\_ If so, how much? This includes coffee, tea, energy drinks, soda \_\_\_\_\_

Do you crave foods? Salty foods, Carbohydrates/Sweets? \_\_\_\_\_

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Do you drink alcohol? \_\_\_\_\_ If yes, how often? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How much daily? \_\_\_\_\_

Do you exercise? \_\_\_\_\_

**Sleep Habits:**

What time do you go to bed? \_\_\_\_\_ Do you fall asleep right away? \_\_\_\_\_

Do you wake up during the night? \_\_\_\_\_ How often? \_\_\_\_\_

Do you then return back to sleep or lay awake? \_\_\_\_\_

Do you feel rested or tired when you arise in morning? \_\_\_\_\_

**Eating Habits:**

How many meals do you eat during the day? \_\_\_\_\_

Describe what you eat? \_\_\_\_\_

Do you snack daily? \_\_\_\_\_ What do you snack? \_\_\_\_\_

Is there any foods you do not eat? \_\_\_\_\_

Do you have any food allergies that you are aware of? \_\_\_\_\_

**Do you have any of these symptoms:**

Stomach Aches      Bloating      Fatigue      Heartburn      Blood in Urine

Constipation      Diarrhea      Gas      Incontinence      Blood in Stool

Do you have history of blood sugar imbalances? Y/N      Diabetes/Hypoglycemia

Please list any other symptoms you may be experiencing \_\_\_\_\_