

# The Menopause Type<sup>®</sup> Questionnaire

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

Date: \_\_\_\_\_

Place an "X" after a question if the answer is "yes" to that question, or any question in that group.

## SECTION A

1. Are you having hot flashes or night sweats, or both? \_\_\_\_\_
2. Are you feeling more depressed? Are you more withdrawn or isolated? Do you feel periods of hopelessness? Do you feel apathetic? \_\_\_\_\_
3. Do you feel a loss of energy? Do you feel more fatigued? \_\_\_\_\_
4. Do you feel less receptive to sex? Do you feel less sensual? Do you feel that your sex drive is diminished? \_\_\_\_\_
5. Are you having increased vaginal pain, dryness or itching? \_\_\_\_\_
6. Are you having insomnia, difficulty falling to sleep or difficulty staying asleep? \_\_\_\_\_
7. Are you having trouble with your memory? Do you feel like you are having more trouble remembering names? Are you more forgetful? \_\_\_\_\_
8. Is your mood low, less upbeat, less positive or less outgoing? Are you having less "good moods" and times of joy? Do you find yourself caring less about things that used to matter to you? \_\_\_\_\_
9. Are you having trouble controlling your urine? Do you have to go more often? Do you spill urine when you cough or sneeze? \_\_\_\_\_
10. Do you feel as if your perception is weakening, that it takes you longer to notice things? Are you having trouble thinking of the right word when speaking or writing? Do you feel your mental skills are diminishing? \_\_\_\_\_

## SECTION B

1. Are you having more aches and pain? Are you starting to get arthritis? \_\_\_\_\_
2. Are you having more spotting or break-through bleeding? Have you been told you have Dysfunctional Uterine Bleeding? \_\_\_\_\_
3. Do you seem to be getting more inflammations and swellings? \_\_\_\_\_
4. Are your allergies or asthma getting worse, or are you developing new allergies or asthma? \_\_\_\_\_
5. Do you feel like you are having more twitches and spasms? \_\_\_\_\_
6. Are you experiencing times of mental fogginess, or trouble thinking clearly? \_\_\_\_\_
7. Are you having more mood swings? \_\_\_\_\_
8. Do you feel more fatigued? Are you more tired in the morning? \_\_\_\_\_
9. Are you more irritable? Do you have more nervous tension? \_\_\_\_\_
10. Are you experiencing more anxiety? Do you feel more anxious? \_\_\_\_\_

## SECTION C

1. Do you feel less motivated in general? Do you feel less assertive? \_\_\_\_\_
2. Is your libido lessened? Are you having less sexual fantasies or less desire? Are you less likely to become sexually aroused? Are you less pleased with sex? \_\_\_\_\_
3. Are you feeling less composed and in control? \_\_\_\_\_
4. Are you less energetic? \_\_\_\_\_
5. Are you anemic, or think you are anemic? \_\_\_\_\_
6. Are you feeling more irritable? \_\_\_\_\_
7. Do you have less muscle strength? Do you feel weaker? \_\_\_\_\_
8. Are you having more trouble with mental skills requiring logic and problem solving? Are you having trouble focusing and maintaining your attention? \_\_\_\_\_
9. Is your memory weakening? Are you having more trouble remembering things and events? \_\_\_\_\_
10. Do you feel more depressed? Is your mood low, less confident? Are you feeling frightened or afraid? \_\_\_\_\_

## SECTION D

1. Are you noticing more wrinkles around your mouth and eyes? Do you have poor skin tone on you arms legs or hands? Has the skin lost its firmness or fullness? \_\_\_\_\_
2. Do you feel more depressed? \_\_\_\_\_
3. Do you feel more fatigue in general? \_\_\_\_\_
4. Are you having more headaches? \_\_\_\_\_
5. Are you over 45 years old? \_\_\_\_\_

## SECTION E

1. Do your breasts feel as if they are shrinking and sagging? \_\_\_\_\_
2. Are you experiencing more confusion? \_\_\_\_\_
3. Are you experiencing more morning fatigue? \_\_\_\_\_
4. Do you cry more easily, or more often? \_\_\_\_\_
5. Are your hands or feet colder? \_\_\_\_\_

## SECTION F

1. Is your libido less than it used to be? \_\_\_\_\_
2. Is your pubic hair thinning? \_\_\_\_\_
3. Do you feel less motivation, less assertive, less confident? Have you lost your competitive edge? \_\_\_\_\_
4. Are you gaining more fat weight? Do you feel less lean? \_\_\_\_\_
5. Are you having more low back pain or hip pain? Do you feel more joint pain? Are you having more headaches? \_\_\_\_\_

## SECTION G

1. Are you developing more facial Hair (hirsutism)? \_\_\_\_\_
2. Is your voice changing and becoming deeper or less feminine? \_\_\_\_\_
3. Are you having trouble tolerating sugars and carbohydrates? \_\_\_\_\_
4. Are you developing or having increased acne? \_\_\_\_\_
5. Do you feel more hostile, angry, agitated or aggressive? \_\_\_\_\_

Place totals from each sections in the "SECTION TOTALS" column below. Multiply totals as indicated in each of the columns. Then, add the numbers in each column and write in "Totals" row.

SECTION TOTALS	Estro Deficiency	Progesto Deficiency	Testo Deficiency	Testo-Excess
A =	A × 4 =			
B =		B × 5 =		
C =			C × 5 =	
D =	D × 4 =	D × 5 =	D × 5 =	
E =	E × 4 =	E × 5 =		
F =	F × 4 =		F × 5 =	
G =				G × 20 =
	<b>TOTALS:</b>	<b>E =</b>	<b>P =</b>	<b>T =</b>
			<b>A =</b>	

Now, Fold Top of Page Back Down - Then, Write Numbers from "E", "P", "T" & "A" in the boxes on folded page.

**These may be early signs of Perimenopause or Menopause.**

Find out which Menopause Type®, and which natural, hormone free formulations are best for that Menopause Type®

Unfold this brochure and take the Menopause Type® Questionnaire.

Then, place the "E", "P", "T" and "A" numbers in the spaces below.

E  P  T  A

Choose any of the Menopause Type® Formulations in which the score for the letter associated with that formulation is 50 or higher.

**Choose Your Formulations Now:**

- ◆ If E is 50 or more use **Estro-Mend™**.
- ◆ If P is 50 or more use **Progesto-Mend™**.
- ◆ If T is 50 or more use **Testo-Gain™**.
- ◆ If A is 50 or more use **Testo-Quench™**.
- ◆ If the number inside the "T" box is the same as the number in the "A" box, choose **Testo-Quench™**.

For more information about these herbal formulations, see back of this brochure, or log onto: [www.YourMenopauseType.com/Formulations/](http://www.YourMenopauseType.com/Formulations/)

Depending on what your Menopause Type® is, you may need one, two or three formulas.

◆ **Once you determine which Menopause Type® formulations are best for you, use the chart on the back of this brochure to Discover Your Menopause Type®.**

Let your healthcare professional have a copy of your completed questionnaire for your healthcare records.

**Menopause Types®**

	Normal Testosterone	Low Testosterone	High Testosterone
Adequate Estrogen & Adequate Progesterone	<b>Type 1</b>	<b>Type 2</b> Testo-Gain™	<b>Type 3</b> Testo-Quench™
Deficient Estrogen & Adequate Progesterone	<b>Type 4</b> Estro-Mend™	<b>Type 5</b> Estro-Mend™ Testo-Gain™	<b>Type 6</b> Estro-Mend™ Testo-Quench™
Adequate Estrogen & Deficient Progesterone	<b>Type 7</b> Progesto-Mend™	<b>Type 8</b> Progesto-Mend™ Testo-Gain™	<b>Type 9</b> Progesto-Mend™ Testo-Quench™
Deficient Estrogen & Deficient Progesterone	<b>Type 10</b> Estro-Mend™ Progesto-Mend™	<b>Type 11</b> Estro-Mend™ Progesto-Mend™ Testo-Gain™	<b>Type 12</b> Estro-Mend™ Progesto-Mend™ Testo-Quench™

◆ [www.YourMenopauseType.com](http://www.YourMenopauseType.com)

◆ These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure or prevent any disease.

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**WOMEN**



**Do You Have...**

- Fatigue**
- More Aches & Pains**
- Anxiety or Irritability**
- New Allergies**
- Mood Swings**
- Depression**
- Hot Flashes**
- Thinning Hair**
- Dry Skin**
- New Facial Hair**
- Insomnia**
- Night Sweats**
- Decreased Libido**
- Poor Memory**
- Difficulty Concentrating**
- Sugar Intolerance**
- Headaches**
- Weight Gain**

**Significant change in your sense of wellbeing.**

Available through

