



Excellence in Women's Wellbeing

# Questionnaire Hormone coaching

First name, last name .....

Date of birth .....

Adress .....

E-Mail ..... Mobile .....

Weight ..... Height .....

Date .....

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## Problems or issues concerning

(check the appropriate box))	No / none	Occasionally	Yes / often
Decrease in sense of well-being			
Decrease in sense of mental well-being			
Increase in sweating during the day			
Increase in sweating during the night			
Difficulty falling asleep			
Sleep disorders and problems			
Decrease in ability to concentrate			
Decrease in accurate memory			
Lack of energy and motivation			
Problems with joints and muscles			
Noticeable loss of strength			
Increase in wrinkling of skin			
Increase in sleepiness or tired feeling			
Increase in irritability, stress, or restlessness			
Anxiety, feelings of hopelessness or senselessness			
Sadness, despair, depression			
Difficulty in dealing with stress			
Decrease in libido (sexual drive)			
Problem with weight gain			
Hair loss			
Increase in oily hair, or acne			
Dry skin (hands and face)			
Dry eyes			
Vaginal dryness			
Genital burning or itching			
Increased occurrence of bladder infections			

Do you leak urin?  No  
 When coughing / jumping  when you feel the urge to urinate  When standing up

Do you smoke?  No  
 Yes, how many ? .....

Your lowest weight ? ..... Your highest weight? .....

## Births, gynecological surgeries, illnesses

Do you have children?  no  
 If yes, how many ? Vaginal birth : ..... Cesarean: .....

Have you ever had gynecological surgery? If yes, what procedure was performed?

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## Illnesses and surgeries

(check the appropriate box)	No	Yes
Rheumatoid illnesses, including muscle, joint, or back pain		
Arthritis		
Osteoporosis, any spinal or hip fractures, or loss of height		
Stroke / any other neurological illnesses or injuries		
Thrombosis or embolism, other vascular problems or diseases		
Blood circulation problems, high blood pressure, heart attack, or other issues?		
Stomach / intestinal problems		
Other illnesses or surgeries? Please explain:		

Do you have a family history of illness?

- Osteoporosis
- Breast cancer
- Heart attack
- Alzheimer's / dementia
- Diabetes
- Thrombosis / pulmonary embolism

Do you take any medications? Please list all.

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What are your expectations of a Hormone coaching?

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