Menopause Power

My HBTx Journal

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My Personal HBTx Journal

This Personal HBTx Journal is provided so you can document your progress on HBTx. As well it will be useful to record information your physician will need. Remember from Rule Five, your input is very important to guide your physician in making dosage changes. At least for the first 12 months, use this Journal to:

- Record and compare your lab test results.
- Keep track of how you are feeling in comparison with when you started.
- Track the progression of your estradiol and progesterone dosages over time.
- Track your withdrawal bleed.
- Keep other notes as reminders when talking with your doctor.

Baseline Test Results

Hormone Level Tests

Date blood drawn: _____

Estradiol level _____ ng/ml
Progesterone level _____ pg/ml
FSH level _____ mIU/ml

Other Tests/Studies

Date of last mammogram _____ Result: _____
Date of last pap smear _____ Result: _____
Date of last uterine ultrasound _____ Result: _____
Date of last bone mineral density study _____ Result: _____

If you had any other baseline tests or studies done such as: thyroid levels, insulin, HbA1C, fasting blood sugar, cholesterol, adrenal function, or Vitamin D that were abnormal, make a note to that effect below:

_____
_____
_____
_____
_____

Baseline Symptoms and Conditions

Symptoms: Use the list below to document your symptoms at the time you started HBTx. Check *all* of the symptoms you are currently experiencing. I've listed many of the "classic" symptoms and left a few spaces for additional symptoms. Refer to Appendix B of your Take Charge Guide for a list of 100 Symptoms associated with the loss of E2 & P4 to ensure your list is complete. Next to those symptoms that apply to you, make a note regarding frequency, severity, how long you've had them, etc.

- ❑ Hot Flashes _____
- ❑ Night Sweats _____
- ❑ Sleep disruption _____
- ❑ Fatigue _____
- ❑ Irritability _____
- ❑ Lower to no sex drive _____
- ❑ Vaginal dryness _____
- ❑ Hair loss/thinning hair/dry hair _____
- ❑ Achy joints _____
- ❑ Chills _____
- ❑ Thickening waistline _____
- ❑ Tight muscles _____
- ❑ Heart palpitations _____
- ❑ Mood swings _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

Other Health Issues (Conditions): Check other health issues you currently have, especially those that began or became worse when you went into menopause. Fill in any other health issues you have that need to be tracked.

- ❑ Abnormal cholesterol levels
- ❑ Asthma/allergies
- ❑ Bone loss
- ❑ Digestive disorders
- ❑ Frequent migraines
- ❑ Higher blood pressure
- ❑ Increased blood sugar levels
- ❑ Increased insulin levels
- ❑ Inflammation
- ❑ Mood disorders – anxiety/depression
- ❑ Sleep disorders
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

Nutrition and Lifestyle Habits

Complete the following to document you baseline nutrition and lifestyle habits. For details about changing your nutrition and lifestyle habits, including tailoring a plan to your specific needs, refer to the *Schwarzbein Principle – The Program.*

Nutrition

Are you following the balanced nutrition plan as prescribed? Yes No Mostly

If no or mostly, check off all that describes what you are mostly doing:

___ Skipping meals ___ Eating too many carbohydrates ___ Eating too few carbohydrates

___ Skipping snacks ___ Not eating enough vegetables ___ Eating too much fruit

___ Eating damaged fats ___ Not eating enough protein ___ Eating too much protein

___ Eating too many man-made carbohydrates ___ Eating too many high saturated fatty foods

The following are proteins that are often difficult to digest. If this applies to you, are you doing a good job of staying away from:

Gluten Yes No Cow Dairy Yes No Unfermented Soy Yes No

Are you practicing good meal hygiene – sitting in a relaxed setting, taking time to eat slowly, and chewing each bite thoroughly before swallowing?

___Yes ___No ___Working on it.

Stress and Sleep

Stress: Which of the following best describe(s) your current stress(es)?

Family Financial Work-Related Personal Illness Travel Other _____

Describe what you do to help manage your stress(es) – activities, self-medication, etc.

_____

_____

_____

_____

Sleep: Describe your sleep habits and patterns – what time you typically go to sleep, number of hours of uninterrupted sleep, whether you have trouble getting to sleep or staying asleep, what sleep aids you may be using, etc. _____

_____

_____

_____

Self Medication -- Sugar/Chemicals/Stimulants

Are you ingesting any of the following? If yes, please quantify. (For example – coffee 3/day)

Coffee _____ Decaf Coffee _____ Tea _____ Herbal Tea _____ Iced Tea _____

Soda _____ Diet Soda _____ Milk _____ Fruit Juice _____

Sugar _____ Artificial Sweeteners _____ Desserts _____

Alcohol _____ Tobacco/nicotine in any form _____

Other_____

Exercise

Describe the kind(s) of exercise you do, frequency, duration, etc. Are you using exercise as a form of "self-medication?" _____

_____

_____

_____

Other

Other notes about your health, including your mental and emotional health, concerns you have about your health, or about being on HBTx. _____

_____

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Beginning HBTx – The First Month

Estradiol

Start Date: _____

Form (patch/ troche) _____
_____

Starting Dosage: _____

Dosage Adjustments:

1 st Date: _____ Dosage: _____
2nd Date: _____ Dosage: _____
3rd Date: _____ Dosage: _____

Progesterone

Start Date: _____

Form (suppository/intravaginal cream or gel)
_____

Starting Dosage: _____

1st Date: _____ Dosage: _____
2nd Date: _____ Dosage: _____
3rd Date: _____ Dosage: _____

How are you feeling?

For each week, summarize how you are feeling, whether you are feeling any different at all, feeling better, or experiencing any adverse effects, etc.

Week 1: _____
_____
_____

Week 2: _____
_____
_____

Week 3: _____
_____
_____

Week 4: _____
_____
_____

List below the Baseline Symptoms and Conditions that you checked in the above lists. To the right of each entry, indicate any changes that may have occurred.

Symptoms/ Conditions	Changes to Symptoms/Conditions

Beginning HBTx – The Second Month

Starting Date: _____

Current E2 Dosage: _____

Current P4 Dosage: _____

Dosage Adjustments:

1 st	Date: _____	Dosage: _____	**1st**	Date: _____	Dosage: _____
2nd	Date: _____	Dosage: _____	**2nd**	Date: _____	Dosage: _____
3rd	Date: _____	Dosage: _____	**3rd**	Date: _____	Dosage: _____

How are you feeling?

For each week, summarize how you are feeling, whether you are feeling any different at all, feeling better, or experiencing any adverse effects, etc.

Week 1: _____
_____
_____

Week 2: _____
_____
_____

Week 3: _____
_____
_____

Week 4:: _____
_____
_____

List below the Baseline Symptoms and Conditions that you checked in the above lists. To the right of each entry, indicate any changes that may have occurred.

Symptoms/ Conditions	Changes

HBTx Journal – The Next Six Months

From _____ to _____

For each month, fill in the most current hormone test level and the dosage you were on. In the Symptoms/Conditions section, in the left column, fill in the Baseline Symptoms and Conditions that you checked in the above lists. To the right of each entry, indicate whether the respective symptom is Better (B), Worse (W), About the Same (S), or Gone (G).

Hormone Test Levels	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8
Estradiol						
Progesterone						
FSH						
Hormone Dosages						
Estradiol						
Progesterone						
Symptoms/Conditions						

Notes: Indicate any other noteworthy information about how you are feeling, changes you have made to your diet or eating habits, changes in your stress levels and how you are managing stress, how you are sleeping, any changes in the way you self-medicate, and changes in your exercise regimen.

_____

_____

_____

_____

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_____

HBTx Journal – The Subsequent Six Months From _____ to _____

For each month, fill in the most current hormone test level and the dosage you were on. In the Symptoms/Conditions section, in the left column, fill in the Baseline Symptoms and Conditions that you checked in the above lists. To the right of each entry, indicate whether the respective symptom is Better (B), Worse (W), About the Same (S), or Gone (G).

Hormone Test Levels						
	Month 9	Month 10	Month 11	Month 12	Month 13	Month 14
Estradiol						
Progesterone						
FSH						
Hormone Dosages						
Estradiol						
Progesterone						
Symptoms/ Conditions						

Notes: Indicate any other noteworthy information about how you are feeling, changes you have made to your diet or eating habits, changes in your stress levels and how you are managing stress, how you are sleeping, any changes in the way you self-medicate, and changes in your exercise regimen.

_____

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_____

_____

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Menstrual Cycle Calendar for _____ (year)

Name: _____

MR# (office use only): _____

Please place these symbols in the boxes above the dates during your period to indicate the amount of bleeding on that day:

Spotting	Light Flow	Normal	Heavy	Very Heavy
	3-4 hours	2-3 hours	1-2 hours	Every hour

January

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

February

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29

March

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

April

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	20

May

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

June

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	20

July

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

August

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

September

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	20

October

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

November

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	20

December

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

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The Menopause Power Menstrual Calendar – Instructions

This *Menopause Power Menstrual Calendar* is used to help keep track of your monthly withdrawal bleed. Remember, we are expecting normal responses to restoring hormone balance. Correctly restoring E2 & P4 creates the same conditions that used to cause your monthly bleed.

Normally, this monthly "period" will occur anywhere from the last few days of your taking progesterone to two days after the last progesterone dosage of the "new" cycle. For instance, give or take a few days:

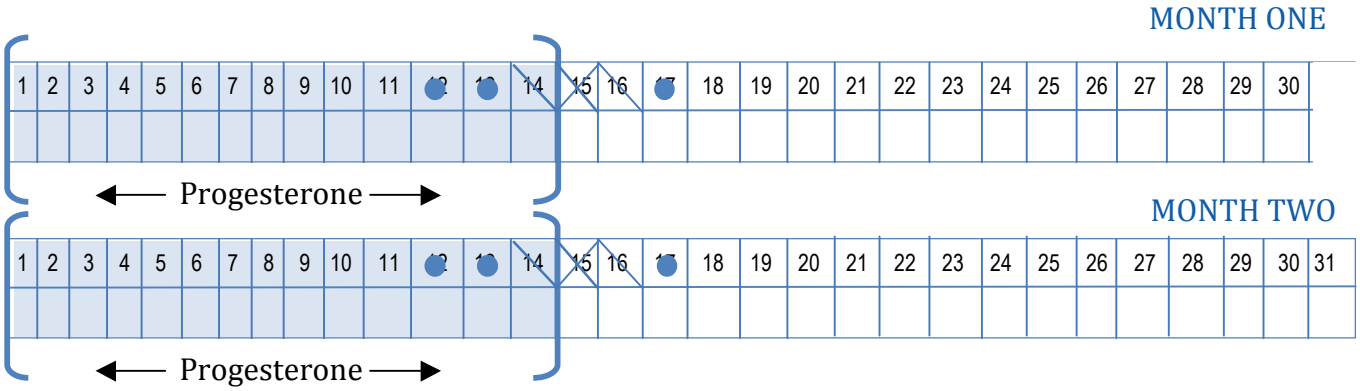
- If you take progesterone on calendar days 1 to 14, a normal time to start your withdrawal bleed would be between calendar days 12 to 16.
- If you are on progesterone from calendar days 15 to 28, you should expect your bleed to begin between calendar days 26 to 30.
- If you are cycling on days 18 to 28 (not calendar days, but cycle days) then, when you are back in balance, you should expect your bleed to start somewhere between cycle days 26 to 2.

When your hormones are balanced, you should expect to see normal flow and normal consistency.

- Your flow should be similar to what it was prior to menopause, and there should be minimal to no clotting.
- If your flow is scanty, it indicates that, either your estradiol dosage is too low, your progesterone dosage is too high, or both.
- If you are experiencing a lot of clotting or are having heavy periods, it is likely that your progesterone dosage is too low and/or your estradiol dosage is too high. Be sure to let your doctor know if this occurs.

Marking Your Calendar

- Use the same calendar continuously for each calendar year; start a new calendar each January.
- Bracket the days you start and stop the supplemental progesterone to: 1) help you remember the days to start and stop your progesterone; and, 2) to help your doctor correlate the timing of your flow with your progesterone phase.
- Mark the calendar using the appropriate symbol (see upper right of calendar) to indicate the amount of your daily flow. Place these symbols in the boxes above the respective dates of your withdrawal bleed. The number of hours shown below the symbols refers to the frequency with which you are needing to change your tampon or sanitary napkin.



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