

SELF TEST: DO YOU HAVE PCOS?

Poly-Cystic Ovary Syndrome (PCOS) is characterized by multiple small ovarian cysts, obesity, hypertension, diabetes, insulin resistance, and hirsutism (elevated levels of male hormones). The ovarian cysts may not produce any definite symptoms, and may come and go, so they may not show on ultrasound at the time the test is done. It may, therefore, be difficult to prove the presence of this disorder. In view of the combined cluster of problems you are experiencing (weight gain, glucose intolerance and almost certain insulin resistance, hormonal imbalances, high blood pressure), it may be reasonable to make treatment recommendations based on what would be appropriate for PCOS.

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|------------------------------|-----------------------------|--|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 1. I crave carbohydrates and sugar. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 2. I have had continuous weight gain. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 3. I have always had difficulty with losing weight. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 4. My waistline is greater than 35 inches. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 5. I have or had problems in the past with acne. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 6. My periods last longer than 35 days. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 7. My periods are unpredictable. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 8. My periods last longer than a week. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 9. My periods are very heavy or prolonged. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 10. I have with excess facial hair. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 11. I have symptoms of hypoglycemia. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 12. I have a family history of diabetes. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 13. I have a family history of cardiovascular disease. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 14. I have a history of gestational diabetes. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 15. I feel extremely hungry, irritable, sleepy, or fatigued after eating sweets. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 16. I have noticed skin color or pigmentation changes. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 17. I have a history of high blood pressure. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 18. I have had difficulties getting pregnant. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 19. I have PMS symptoms. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 20. I have unusual amount of hair on my breasts. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 21. I have hair growth on my upper thighs. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 22. I have pubic hair that grows up my abdomen and around the navel. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | 23. My acne is worse at different times of my cycle. |