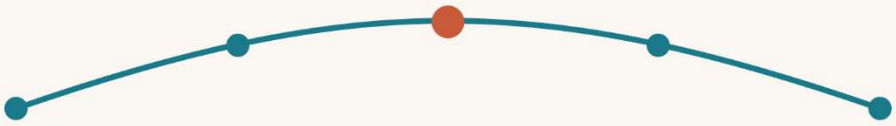
THE FEMALE VARIABLE

What to Say to Your Doctor

A POCKET REFERENCE

The scripts, the numbers, and the questions you'll wish you had asked.



A COMPANION TO THE HORMONE DECISION

thefemalevariable.substack.com

THE HORMONE DECISION

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WHAT'S INSIDE

Companion to The Hormone Decision

Free for readers at

theFemaleVariable.com

Before You Walk In

You practiced your opening line. You have your symptom data. You're ready. And then you're in the paper gown and the doctor says something that closes the conversation before it began.

This pocket reference exists for that moment. The six scripts in Part 1 are grounded in the evidence from **The Hormone Decision**. They're not combative. They're not demanding. They're specific — which is what converts a dismissal into a real clinical conversation.

Part 2 gives you a number-literacy tool: a way to translate a relative risk percentage into an absolute one, right there in the appointment, using your own risk profile from Chapter 2.

Part 3 is the list of questions most women never ask — and later wish they had.

> **Not medical advice.** Use this reference to have a better conversation with your qualified healthcare provider. Your provider knows your full medical history. This book does not.

PART 1 — THE 6 SCRIPTS

Each card names the scenario, shows what you might hear, gives you an evidence-grounded response, and explains why it works.

SCRIPT 1 — 'Let's just wait and see'

THEY SAY

"You're still young. These things often settle down. Let's give it a few more months."

YOU CAN SAY

"I can wait if there's a specific reason — what would change in three months that isn't already true now? I've been tracking my symptoms for eight weeks and they're getting worse, not better. I'd rather act on what I know than wait for something we haven't defined."

WHY THIS WORKS

Vague deferrals aren't a treatment plan. Asking what you're waiting for converts an open-ended delay into an accountable clinical question. It's not confrontational — it's precise.

SCRIPT 2 — 'Hormones are dangerous'

THEY SAY

"After what the Women's Health Initiative showed, I can't in good conscience recommend HRT to most of my patients."

YOU CAN SAY

"I've been reading about the WHI and the subsequent reanalysis. My understanding is that the findings applied to older women — average age 63 — taking specific formulations. I'm [age], [years] post-menopause, and I'm wondering whether those risks apply to my specific situation. Can we look at my individual profile?"

WHY THIS WORKS

This is factually accurate and non-argumentative. It invites the doctor to apply the evidence correctly rather than categorically. The WHI findings are real — the point is that they're population-specific, not universal. And in 2025 the FDA began revising the long-standing boxed warning on estrogen products — worth noting if your doctor is still working from the old label.

SCRIPT 3 — 'It's natural, just deal with it'

THEY SAY

"Menopause is a natural transition. Most women get through it without medication."

YOU CAN SAY

"I understand it's natural. I'm asking about evidence-based options for managing symptoms that are significantly impairing my quality of life — I'm not sleeping, I'm losing words in meetings, my relationships are suffering. I'm not asking to fix menopause. I'm asking for help with symptoms that are disrupting my ability to function."

WHY THIS WORKS

This reframes the conversation from philosophy ('is menopause a disease?') to function ('my symptoms are measurably affecting my life'). It's harder to dismiss a specific list of functional impairments than a general complaint.

SCRIPT 4 — Prescription without explanation

THEY SAY

"[Doctor writes prescription and starts moving toward the door]"

YOU CAN SAY

"Before I fill this — can we talk through why this specific formulation and dose? I'd like to understand the reasoning, what alternatives we considered, and what to expect in the first month so I know what's normal."

WHY THIS WORKS

A prescription you don't understand is a prescription you won't take consistently. This question is reasonable and brief. It models the behaviour the doctor should be providing by default. Most providers will answer it willingly.

SCRIPT 5 — Family history used as a blanket veto

THEY SAY

"Given your family history of breast cancer, I don't think hormone therapy is a good idea for you."

YOU CAN SAY

"I understand that's a concern. Could we look at my specific family history — my mother was [age] at diagnosis, [receptor type if known], [other relatives affected or not]. I'd like to understand whether that history changes my individual risk significantly, and whether formulation choice — estrogen-only, transdermal, lower dose — affects that calculation."

WHY THIS WORKS

Family history matters but doesn't automatically contraindicate HRT. Asking for specificity moves the conversation from a reflex ('family history = no HRT') to an individualized assessment, which is what the evidence actually supports.

SCRIPT 6 — The appointment ends unsatisfactorily

THEY SAY

"[You leave feeling unheard, unsure, or with unanswered questions]"

YOU CAN SAY

"I appreciate your time. I think I need to do more reading before I decide. Could I schedule a follow-up once I've processed this — or would you recommend a menopause specialist I could consult for a second opinion?"

WHY THIS WORKS

You are not required to leave with a decision you don't understand or accept a dismissal that doesn't fit the evidence. Asking for a second opinion is not 'doctor shopping' — it's informed self-advocacy. The Menopause Society directory lists certified practitioners.

PART 2 — READING A RISK NUMBER

When your doctor quotes a percentage

'HRT increases breast cancer risk by 26%.' That number terrified a generation of women — and was reported without the context that makes it meaningful. Here's the tool.

The rule: always convert relative risk to absolute risk.

Relative risk: how much MORE likely, compared to the baseline (sounds big).

Absolute risk: how many additional people out of 1,000 — or 10,000 — are actually affected (usually small).

The question to ask: *"26% increase in what? How many additional cases per 1,000 women? In women my age, on this formulation, over how many years?"*

Common HRT risk claims — in absolute terms

These are absolute numbers — actual cases per 1,000 or per 10,000 women in a year, not relative percentages. Based on the WHI and major observational data; Chapter 5 has the full picture.

	Without HRT	With combined HRT
Breast cancer (combined HRT, 5 years)	about 30 in 10,000 **baseline, per year**	about 38 in 10,000 **about 8 more a year**

	Without HRT	With estrogen only
Breast cancer (estrogen only, no uterus)	about 30 in 10,000 **baseline, per year**	No increase **small possible drop**

	Without HRT	With oral estrogen
Blood clot (oral estrogen)	about 1–2 in 1,000 **baseline, per year**	about 2–4 in 1,000 **roughly double**

	Without HRT	With transdermal
Blood clot (transdermal estrogen)	about 1–2 in 1,000 **baseline, per year**	about 1–2 in 1,000 **not raised**

	Without HRT	With estrogen
Hip fracture (estrogen, bone protection)	Baseline **after menopause**	about a third fewer **hip & spine fractures**

Key formulation note: The transdermal blood clot row is the single most important line for women with elevated clotting risk. Oral estrogen raises it. Transdermal does not. This is not a minor distinction — for some women it determines whether HRT is even an option.

To use your own risk numbers: Complete Domain 2 (breast cancer) and Domain 3 (cardiovascular/clotting) in the Workbook. Your specific risk factors change which row in this table is most relevant to you.

See Chapters 2 and 5 in *The Hormone Decision*.

PART 3 — THE 12 QUESTIONS YOU FORGOT TO ASK

These are the questions most women leave the appointment wishing they'd asked. Check the ones relevant to you before you go in. Use a pen.

BEFORE STARTING

- ☐ Which specific formulation are you recommending — and why that one for me?
- ☐ Why transdermal vs oral for my risk profile?
- ☐ Why micronized progesterone vs a synthetic progestin?
- ☐ What is the lowest effective starting dose for my symptoms?

IN THE FIRST MONTH

- ☐ What side effects are normal in the first 4–8 weeks?
- ☐ What side effects should make me call you?
- ☐ What are the red-flag symptoms that mean go to the ER?
- ☐ When should I expect to notice a difference in my symptoms?

ONGOING CARE

- ☐ When and how will we review whether this is working?
- ☐ Is there a point when you'd recommend stopping — and what would trigger that?
- ☐ If I want to stop, should I taper or stop abruptly?
- ☐ What monitoring — mammograms, bone density, blood pressure — should I be having, and how often?

If your provider can't or won't answer these questions: that's important information. The Menopause Society directory at menopause.org lists certified practitioners. Menopause-focused telehealth includes Midi, Gennev, Alloy, Evernow, and Winona; services that mainly prescribe compounded hormones warrant extra scrutiny.

PART 4 — SEXUAL & VAGINAL HEALTH

Most women forget half of these symptoms under pressure. Specificity is what turns a shrug into a treatment.

How to use this: Tick the symptoms that apply, decide whether you need a moisturizer, a lubricant, or a prescription, and borrow the script that fits.

GSM symptom checklist — raise the ones that apply

- ☐ Vaginal dryness
- ☐ Burning, rawness, or itching
- ☐ Pain or discomfort with sex — a dry, burning, tearing feeling
- ☐ Reduced lubrication or arousal
- ☐ Light bleeding or spotting after sex
- ☐ Urinary urgency or frequency
- ☐ Recurrent UTIs (two or more a year)
- ☐ Discomfort with exercise or prolonged sitting

GSM is chronic and progressive — untreated, it worsens. Naming it as a medical condition is the first step to treating it.

Moisturizer vs. lubricant — different jobs

Most women who think "nothing non-hormonal works" were using only one of these.

What it is	How it's used — and what it does
Vaginal moisturizer	Used regularly (every few days), not tied to sex. Rehydrates the tissue over time.
Lubricant	Used at the time of sex. Reduces friction in the moment.
Low-dose vaginal estrogen	Prescription. Treats the underlying tissue change. Acts locally, doesn't raise clot risk, and at standard doses needs no progestogen — often the whole answer when GSM is the only problem. [Strong]
Further options	Prasterone (Intrarosa) and ospemifene (Osphena) are additional prescription options worth asking about.

Appointment scripts — borrow the words

To open it at all: *"I have vaginal and urinary symptoms that are affecting my comfort and my relationship, and I'd like to treat them, not just confirm they're common."*

For pain with sex: *"Sex has become painful — a burning, dry, raw feeling. I've tried lubricants and it isn't enough. Is low-dose vaginal estrogen or another option appropriate for me?"*

For recurrent UTIs: *"I keep getting urinary infections. I've read that vaginal estrogen can reduce recurrence. Could that fit my situation?"*

If you've been told you can't take hormones (incl. after cancer): *"I understand systemic hormones aren't an option for me. Is low-dose vaginal estrogen — which I've read acts locally with minimal absorption — a separate conversation I can have, perhaps with my oncologist's input?"*

For desire specifically: *"My desire has dropped in a way that distresses me. Before we consider whether testosterone is relevant, can we rule out the other causes — pain, sleep, mood, medications?"*

Two facts to hold: Local is not systemic — low-dose vaginal estrogen acts where it's applied, doesn't raise clot risk, and usually needs no progestogen. And "you can't take hormones" rarely rules out vaginal estrogen, including for many breast cancer survivors after an oncology-aware conversation.

PART 5 — THE OPTIMIZATION MARKETPLACE

When someone profits from your confusion, clarity is the one thing they cannot sell you. Run this before any peptide, GLP-1, pellet, panel, or "optimization" package.

How to use this: Refuse the bundling. "Optimization" routinely collapses three decisions — a metabolic question, a hormone question, and an anti-aging experiment — into one recurring monthly charge. The filter keeps them apart.

The decision filter — six questions

The question	Green flag	Red flag
What problem are we treating?	Obesity, diabetes risk, a diagnosed deficiency — a clear endpoint	"Optimization," "anti-aging," "balance," or a product-first pitch
Is it FDA-approved for this use?	An approved drug, labeled indication, standard dose	A compounded copy, a "research chemical," or "same ingredient" marketing
What's the evidence tier?	Large trials, guidelines, a measurable endpoint	Testimonials, before/after photos, animal data sold as human proof
Who monitors it?	Clinician-led follow-up, a side-effect plan, labs when appropriate	A membership clinic, a product bundle, no adverse-event plan
What are the off-ramps?	A trial length and clear stop/change criteria	An indefinite subscription with no endpoint
What does it replace?	Complements nutrition, training, sleep, real metabolic care	Sold instead of an indicated treatment or basic evaluation

Financial-conflict questions — ask directly

Mainstream care separates prescribing from dispensing, so the person recommending a product doesn't profit from selling it. The optimization model collapses that separation.

- ☐ "Do you or your practice have any financial relationship with the pharmacy, lab, or product you're recommending?"
- ☐ "Is there an FDA-approved option for my actual symptom?"
- ☐ "What does that approved option cost by comparison?"
- ☐ "What do the major medical societies recommend here?"

“Is this medicine or marketing?”

Each is a common entry point to a recurring charge for an unproven benefit. Check any you’re being offered, then apply the filter above:

☐ Salivary hormone testing — not validated for diagnosing menopause or guiding therapy

☐ “Estrogen dominance,” “hormone balancing,” or “adrenal fatigue” — not recognized diagnoses

☐ A sprawling “anti-aging” panel — a panel ordered to find something always finds something

☐ Hormone pellets — can’t be adjusted once implanted; often supraphysiological; little evidence in women

☐ Compounded GLP-1 “copies” — approved versions exist; the shortage doorways have closed; adverse-event reports

☐ Longevity peptides (sermorelin, ipamorelin, CJC-1295, BPC-157, TB-500) — mostly mechanism and marketing

☐ Auto-shipped supplement boxes — “natural support” is a marketing phrase, not a clinical indication

Bottom line: Bring the problem, not the product. The burden of proof rises for any injectable, pellet, or compounded product sold outside ordinary approved-drug pathways — it doesn’t fall because the word changed from “hormone” to “peptide.”

Quick Reference

Key terms

Relative risk: How much more likely — expressed as a percentage increase vs a comparison group. Sounds large.

Absolute risk: How many additional cases per 1,000 or 10,000 people. Usually small.

Transdermal: Absorbed through the skin (patch, gel, spray). Bypasses first-pass liver metabolism. Does not raise clotting risk.

Oral: Taken by mouth. Passes through the liver first. Raises clotting-factor production. Avoid if you have elevated VTE risk.

Micronized progesterone: Bioidentical progesterone (Prometrium). Most favourable breast cancer risk signal of available progestogens. Take at bedtime — sedating.

[Strong] / [Moderate] / [Emerging] / [Anecdotal]: The evidence tier system from The Hormone Decision. Always ask: what tier is this claim?

GSM: Genitourinary syndrome of menopause — vaginal dryness, urinary urgency, painful sex. Highly treatable with local estrogen even for women who cannot use systemic HRT.

The Menopause Society: The Menopause Society (formerly NAMS). menopause.org — certified-practitioner directory.

Get the full Workbook

The **Hormone Decision Workbook** includes the full 14-day symptom tracker, 8-domain risk profile, the 'What I'm Walking In With' page, first month log, and 5 years of annual review spreads — free at The Female Variable (thefemalevariable.substack.com) for anyone who owns The Hormone Decision or subscribes to the newsletter.

Free digital tools

Printable versions of all workbook pages, the Evidence Cheat Sheet, and Annual Review PDFs: **theFemaleVariable.com**

Not pro-HRT. Not anti-HRT. Pro-you.

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