

Menopause Symptom Assessment

Name «Firstname» «Surname»
DoB «DOB»

The list below includes symptoms that you may be experiencing. Please indicate with a cross if each applies to you and to what extent. Your answers will assist in understanding your problems and in monitoring the success of treatment.

Date

	None	Mild	Mod.	Severe
Daytime sweats and flushes				
Night sweats and flushes				
Unable to sleep				
Headaches				
Tiredness				
Loss of energy				
General aches and pains				
General itchiness				
Formication (sensation of something crawling all over you)				
Emotional problems				
Tearfulness				
Depression				
Feeling of unworthiness				
Irritability				
Anger				
Bitterness				
Panic attacks				
Palpitations				
Aggression				
Bladder Problems				
Daytime frequency (need to pass urine often)				
Urgency (having very little warning)				
Urge incontinence (leakage if you do not get there in time)				
Stress incontinence (leakage if you cough, sneeze or laugh)				
Night-time frequency				
Bed wetting				
Sexual problems				
Vaginal dryness/soreness				
Vaginal itching				
Soreness/pain with intercourse				
Bleeding with intercourse				
Loss of libido (sex drive)				
Difficulty achieving orgasm				
Personality problems				
Loss of memory				
Loss of concentration				
Inability to cope				
Feelings of personality disintegration (not feeling yourself)				
Period problems				
Periods increasingly erratic				
Periods much lighter				
Periods much heavier				
Irregular bleeding between periods				
New bleed over 1 year since periods stopped				