Patient Name: _____

	Absent	Mild	Moderate	Severe
Hot Flashes	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
Vaginal Dryness	_____	_____	_____	_____
Incontinence	_____	_____	_____	_____
Bleeding Changes	_____	_____	_____	_____
Fibrocystic Breast	_____	_____	_____	_____
Weight Gain	_____	_____	_____	_____
Fluid Retention	_____	_____	_____	_____
Dry Skin/Hair	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Breast Tenderness	_____	_____	_____	_____
Cramps	_____	_____	_____	_____
Difficulty Falling Asleep	_____	_____	_____	_____
Difficulty Staying Asleep	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Loss of Memory	_____	_____	_____	_____
Foggy Thinking	_____	_____	_____	_____
Acne	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Decreased Sex Drive	_____	_____	_____	_____
Harder to Reach Climax	_____	_____	_____	_____
Stress	_____	_____	_____	_____

Other: _____

_____