

Symptom Checklist -- Female

Name: _____

Date: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Fatigue.....				
Hot flashes.....				
Night sweats.....				
Moodiness.....				
Anxiety.....				
Depressed mood				
Migraine/severe headaches				
Decreased sex drive/libido				
Difficult to climax sexually				
Decreased clarity ("brain fog").....				
Decreased motivation.....				
Interrupted sleep.....				
Waking early, unable to go back to sleep				
Vaginal dryness.....				
Joint pain/achiness.....				
Breast tenderness.....				
Weight gain.....				
Constipation.....				
Feel cold all the time.....				
Feel hot all the time.....				
Feeling "disconnected from my body"				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		