



## 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       |    |     |