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Menopause Symptoms Checklist
Patient Name: _____
DOB: _____
****please rate the severity on a scale of 0-5 (0=mild 5=severe)**

Date									
Hot flashes									
Night sweats									
Sleeplessness									
Mood swings									
Panic attack									
Memory problems									
Low sex drive									
Itchy skin									
Sore breasts									
Headaches									
Fatigue									
Hair loss/growth									
Incontinence									
Vaginal bleeding									
Vaginal dryness									
Vaginal burning/itching									
Painful intercourse									
Other:									