Name: _____

Have you had any of these symptoms over the past 3 months?

SYMPTOMS	NEVER	MILD	MODERATE	SEVERE
Hot Flashes				
Night Sweats				
Bleeding after Menopause				
Vaginal Dryness				
Decreased Sex Drive				
Decreased Sexual Response				
Painful Intercourse				
Irregular periods				
Hair Loss				
Skin Problems				
Irritability				
Anxiety				
Difficulty Falling Asleep				
Difficulty Staying Asleep				
Fatigue				
Memory Problems				
Migraines Headaches				
Breast Tenderness				
Muscle or Joint Pain				
Constipation				
Diarrhea				

SYMPTOMS	NEVER	MILD	MODERATE	SEVERE
Weight Gain				
Bloating After Eating				
Urinary Frequency				
Urinary Incontinence				
Vulva Pain or Burning				
Vulva Lesion				
Vaginal Discharge (Chronic)				

If you answered any of the last 5 questions as “moderate” or “severe, please proceed to the vulva questionnaire.