Female Symptoms Sheet

Name: _____ **Date:** _____

Symptoms (Please check mark)	Never	Mild	Moderate	Severe	Very Severe
Hot Flashes					
Sweating (Nght sweats, Inceased episodes of sweating)					
Sleep problems (Difficulty falling asleep, Sleeping through the night, Waking up too early					
Depressive mood (Feeling down, Sad, On the verge of tears, Lack of drive)					
Irritability (Mood swings, feeling aggressive, angers easily)					
Anxiety (Inner restlessness, feeling panicked, feeling nervous, inner tension)					
Physical exhaustion (General decrease in muscle strength, fatigue, lack of energy, stamina or motivation)					
Sexual problems (Change in sexual desire, sexual activity, orgasm and/or satisfaction)					
Bladder problems (Difficulty urinating, increased need to urinate, incontinence)					
Vaginal Symptoms (Sensation of dryness or burning vagina, difficulty with sexual intercourse)					
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)					
Difficulties with memory					
Problems with thinking, concentration or reasoning					
Difficulty learning new things					
Trouble thinking of the right word to describe persons, places or things when speaking					
Increase in frequency or intensity of headaches/migraines					
Hair loss, thinning or change in testure of hair					
Feeling cold all of the time or having cold hands and/or feet					
Weeight gain, belly fat or difficulty losing weight despite diet and exercise					
Dry or wrinkled skin					

Yes / No Acne
Yes / No Facial hair
Yes / No Breast tenderness
Yes / No Premenstrual migraines
Yes / No Hot flashes
Yes / No Are you still menstruating? **Last Period** _____
Yes / No Are you on birth control? **Type/Name** _____
Yes / No Do you have the desire to have more children?
Yes / No Are you currently taking thyroid medications? **Name & Dosage** _____

Yes / No Hysterectomy Partial / Total
Yes / No Personal history of breast cancer
Yes / No Fibrocystic Disease
Yes / No PCOS (Polycystic Ovarian Syndrome)
Yes / No Epilepsy / Seizures
Yes / No Endometriosis
Yes / No Leiomyoma / Endometrial Polyps
Yes / No Hashimoto's Thyroiditis

Last mammogram: _____ **Last PAP smear:** _____

Daily physical activity level? **Low / Moderate / High**