CENTER FOR WOMEN'S HEALTH

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Name: _____ Date: _____

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Symptom (please check mark)	Never	Mild	Moderate	severe
Depressive mood				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep Problems				
Mood changes/Irritability				
Tension				
Migraine/sever headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and wrinkled skin				
Hair falling out				
Cold all the time				
Swelling all over the body				
Joint pain				
Fatigue				

Family History

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