

# Symptoms Survey

Instruction: Please circle on a scale of 1-10 (1 rarely happens or very mild, 5 happen more than occasionally or moderate, and 10 is severe or happens very frequently. Circle 0 if it is not a problem for you.

<u>Hot Flashes</u>	0	1	2	3	4	5	6	7	8	9	10
<u>Night Sweats</u>	0	1	2	3	4	5	6	7	8	9	10
<u>Memory Loss</u>	0	1	2	3	4	5	6	7	8	9	10
<u>Bladder Leakage</u>	0	1	2	3	4	5	6	7	8	9	10
<u>Vaginal Dryness</u>	0	1	2	3	4	5	6	7	8	9	10
<u>Fatigue</u>	0	1	2	3	4	5	6	7	8	9	10
<u>Weight Gain</u>	0	1	2	3	4	5	6	7	8	9	10
<u>Depression</u>	0	1	2	3	4	5	6	7	8	9	10
<u>Dry Skin/Hair</u>	0	1	2	3	4	5	6	7	8	9	10
<u>Hair Loss</u>	0	1	2	3	4	5	6	7	8	9	10
<u>Cold Hands/Feet</u>	0	1	2	3	4	5	6	7	8	9	10
<u>Breast Cysts</u>	0	1	2	3	4	5	6	7	8	9	10
<u>Mood Swings</u>	0	1	2	3	4	5	6	7	8	9	10
<u>Insomnia</u>	0	1	2	3	4	5	6	7	8	9	10
<u>Fluid Retention</u>	0	1	2	3	4	5	6	7	8	9	10
<u>Breast Tenderness</u>	0	1	2	3	4	5	6	7	8	9	10
<u>Heavy Periods</u>	0	1	2	3	4	5	6	7	8	9	10
<u>PMS</u>	0	1	2	3	4	5	6	7	8	9	10
<u>Anxiety</u>	0	1	2	3	4	5	6	7	8	9	10
<u>Migraines</u>	0	1	2	3	4	5	6	7	8	9	10
<u>Low Sex Drive</u>	0	1	2	3	4	5	6	7	8	9	10
<u>Bloating/Gas</u>	0	1	2	3	4	5	6	7	8	9	10