Name ______________________________ Date _______________

	NEVER	MILD	MODERATE	SEVERE
Mood changes/ Irritability	________	________	________	________
Tension	________	________	________	________
Depression	________	________	________	________
Memory Loss	________	________	________	________
Mental confusion	________	________	________	________
Nervousness	________	________	________	________
Migraine/severe headaches	________	________	________	________
Decreased sex drive/libido	________	________	________	________
Difficult to climax sexually	________	________	________	________
Bloating	________	________	________	________
Weight gain	________	________	________	________
Fatigue	________	________	________	________
Vaginal dryness	________	________	________	________
Breast tenderness	________	________	________	________
Hot flashes	________	________	________	________
Night sweats	________	________	________	________
Sleep disruption/Insomnia	________	________	________	________
Bladder symptoms	________	________	________	________
Joint pain	________	________	________	________
Hair loss	________	________	________	________