

Symptoms Sheets for Females

Name _____ Date _____

Do you experience any of the following?

Symptoms	None	Mild	Moderate	Severe
Night Sweats				
Hot Flashes				
Vaginal Dryness				
Mood Swings, Irritability				
Anxiety				
Sleeping difficulties or Insomnia				
Fatigue				
No sex drive				
Depression				
Difficulty focusing/concentrating				
Frequent urinary tract infections				
Incontinence				
Dry hair and/or skin				
Migraine headaches				
Weight gain				
Palpitations/irregular heartbeats				