Symptom Chart

Name:
Date:

It would be helpful if you could complete the symptom chart prior to your consultation. Please use a scale of 0 to 5 to describe how you feel about each symptom.

0 = no symptom and 5 = severe symptom

		0	1	2	3	4	5
General	Hot flushes	☐	☐	☐	☐	☐	☐
	Night sweats	☐	☐	☐	☐	☐	☐
	Poor sleep	☐	☐	☐	☐	☐	☐
	Tiredness	☐	☐	☐	☐	☐	☐
	Headaches	☐	☐	☐	☐	☐	☐
	General aches and pains	☐	☐	☐	☐	☐	☐
	Palpitations	☐	☐	☐	☐	☐	☐
	Weight gain	☐	☐	☐	☐	☐	☐
Emotional	Mood swings	☐	☐	☐	☐	☐	☐
	Low mood	☐	☐	☐	☐	☐	☐
	Depression	☐	☐	☐	☐	☐	☐
	Tension	☐	☐	☐	☐	☐	☐
	Irritability	☐	☐	☐	☐	☐	☐
	Panic attacks	☐	☐	☐	☐	☐	☐
Mental	Difficulty concentrating	☐	☐	☐	☐	☐	☐
	Memory problems	☐	☐	☐	☐	☐	☐
	Difficulty coping	☐	☐	☐	☐	☐	☐
	Loss of efficiency	☐	☐	☐	☐	☐	☐
Sexual	Low libido (sex drive)	☐	☐	☐	☐	☐	☐
	Vaginal dryness	☐	☐	☐	☐	☐	☐
	Soreness/pain with intercourse	☐	☐	☐	☐	☐	☐
	Bleeding during intercourse	☐	☐	☐	☐	☐	☐
Skin	Dry skin	☐	☐	☐	☐	☐	☐
	Dry eyes	☐	☐	☐	☐	☐	☐
	Acne	☐	☐	☐	☐	☐	☐
	Hair loss	☐	☐	☐	☐	☐	☐
	General itchiness	☐	☐	☐	☐	☐	☐

Name:

Date:

		0	1	2	3	4	5
Bladder (urinary symptoms)	Urgency	☐	☐	☐	☐	☐	☐
	Frequency during the day	☐	☐	☐	☐	☐	☐
	Getting up at night to pass urine	☐	☐	☐	☐	☐	☐
	Urge incontinence (urine leakage if you do not get there in time)	☐	☐	☐	☐	☐	☐
	Stress incontinence (urine leakage with cough, sneeze or laugh)	☐	☐	☐	☐	☐	☐
Periods (bleeds)	Irregular periods	No	☐		Yes	☐	
	Periods much lighter	No	☐		Yes	☐	
	Periods much heavier	No	☐		Yes	☐	
	Bleeding in between periods	No	☐		Yes	☐	
	New bleed over 1 year after periods have stopped	No	☐		Yes	☐	
	Date of last period						

Any other information you would like to add: