



Name: _____ Date of birth: _____

FEMALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	None (0)	Mild (1)	Moderate (2)	Severe (3)	Very severe (4)
Hot flashes	<input type="checkbox"/>				
Sweating (night sweats or increased episodes of sweating)	<input type="checkbox"/>				
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)	<input type="checkbox"/>				
Depressive mood (feeling down, sad, on the verge of tears, lack of drive)	<input type="checkbox"/>				
Irritability (mood swings, feeling aggressive, angers easily)	<input type="checkbox"/>				
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)	<input type="checkbox"/>				
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	<input type="checkbox"/>				
Sexual problems (change in sexual desire, sexual activity, orgasm and/or satisfaction)	<input type="checkbox"/>				
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	<input type="checkbox"/>				
Vaginal symptoms (sensation of dryness or burning in vagina, difficulty with sexual intercourse)	<input type="checkbox"/>				
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	<input type="checkbox"/>				
Difficulties with memory	<input type="checkbox"/>				
Problems with thinking, concentrating or reasoning	<input type="checkbox"/>				
Difficulty learning new things	<input type="checkbox"/>				
Trouble thinking of the right word to describe persons, places or things when speaking	<input type="checkbox"/>				
Increase in frequency or intensity of headaches or migraines	<input type="checkbox"/>				
Hair loss, thinning or change in texture of hair	<input type="checkbox"/>				
Feel cold all the time or have cold hands or feet	<input type="checkbox"/>				
Weight gain or difficulty losing weight despite diet and exercise	<input type="checkbox"/>				
Dry or wrinkled skin	<input type="checkbox"/>				
Total score	_____				

Severity score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80