Rejuvené

FEMALE
SYMPTOM CHECKLIST

Name: _____ **Date:** _____

Which of the following symptoms apply to you at this time? Please mark the appropriate one for each symptom.

____ Hot flashes, sweating	____ Lack of motivation	____ Sleeping problems
____ Night sweats	____ Difficulty concentrating	____ Migraines
____ Depression	____ Foggy thinking	____ Cold body temperature
____ Irritability	____ Mood swings	____ Difficulty losing weight
____ Anxiety	____ Decreased sexual desire	____ Reduced muscle mass
____ Decreased energy	____ Vaginal dryness	____ Reduced bone mass
____ Burned out feeling	____ Pain with intercourse	____ Blood sugar issues
____ Decreased stamina	____ Irregular menstruation	____ Infertility issues
____ Muscle or joint pain	____ Urine leakage	

Do you have any other major symptoms? If yes, please describe:

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