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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