Tayside Sexual & Reproductive Health Service
Menopausal Symptoms Questionnaire

Name: **Date:**

Sticker or CHI number:

Current hormonal and/or non-hormonal treatment for menopausal symptoms:

Please mark a box with a tick (✓) to show if and how much you have been troubled by any of these symptoms over the past four weeks:

Symptoms	Not at all	A little	Quite a bit	A lot
Vasomotor symptoms				
1. Hot flushes during the day				
2. Night sweats				
Tiredness and sleep disturbance				
3. Feeling tired or lacking in energy				
4. Difficulty in concentrating or remembering				
5. Difficulty in sleeping not relating to sweats				
Emotional symptoms				
6. Having lost interest in most things				
7. Feeling unhappy or depressed				
8. Having crying spells				
9. Feeling tense or nervous				
10. Feeling irritable or having mood swings				
11. Having anxiety or panic attacks				
Local and sexual symptoms				
12. Dryness or soreness of vulva and vagina				
13. Discomfort or pain on passing urine				
14. Leaking of urine or lack of bladder control				
15. Discomfort or pain during sex				
16. Loss of interest in sex				
Other symptoms				
17. Headaches				
18. Palpitations (heart beating quickly or strongly)				
19. Parts of body feel numb or tingling				
20. Muscle and joint pains				

Thank you very much for filling out this form!

Please don't forget to have this chart ready when you speak to your doctor or nurse.