



FEMALE Symptom Checklist

Place an "X" for EACH symptom you are currently experiencing. *Please mark only ONE box.* For symptoms that do not apply, please mark NONE.

	None	Mild	Moderate	Severe	Extreme
1 Hot Flashes, sweating (episodes of sweating)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Heart Discomfort (unusual awareness of heartbeat, heart skipping, heart racing, tightness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Sleep Problems (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Irritability (feeling nervous, inner tension, feeling aggressive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Anxiety (feeling panicky)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Physical and Mental Exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Sexual Problems (change in sexual desire, in sexual activity and satisfaction)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Bladder problems (difficulty in urinating, increased need to urinate, bladder incontinence)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Dryness of vagina (sensation of burning, dryness, difficulty with sexual intercourse)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Joint and muscular discomfort (pain in the joints, rheumatoid complaints)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have cold hands and feet? Yes No

Do you have daily bowel movements? Yes No

Do you have gas, bloating or abdominal pain after eating? Yes No

**BRING THIS CHECKLIST WITH YOU AND LEARN HOW WE
CAN HELP MAKE A POSITIVE DIFFERENCE IN YOUR LIFE
TODAY!**