MENOPAUSE AND YOU IS A SUBSIDIARY OF TEAM BEST LIFE

MENOPAUSE AND YOU

Please use this checklist to capture your symptoms.

NAME: _____ **DATE:** _____

Your cycle phase, if known: Periods just finished ☐ Regular Periods ☐ Irregular | Unclear ☐ No Periods ☐

Greene Climacteric Scale

Please indicate the extent to which you are experiencing any of these symptoms by placing a tick in the appropriate box.

SYMPTOMS	NOT AT ALL 0	A LITTLE 1	QUITE A BIT 2	EXTREMELY 3	COMMENTS
Heart beating quickly /strongly					
Feeling tense or nervous					
Difficulty in sleeping					
Irritable					
Attacks of anxiety/panic					
Difficulty in concentrating					
Feeling tired or lacking in energy					
Loss of interest in most things					
Feeling unhappy/depressed					
Crying spells					
Feeling dizzy or faint					
Pressure or tightness in head					
Parts of body feel numb					
Headaches					
Muscle and joint pain					
Loss of feeling in hands or feet					
Breathing difficulties					
Hot Flushes					
Sweating at night					
Loss of interest in sex					
Vaginal changes					