

## FEMALE HEALTH ASSESSMENT QUESTIONNAIRE

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please mark the appropriate box for each symptom you may be experiencing.

| SYMPTOMS                                                                                   | NONE                     | MILD                     | MODERATE                 | SEVERE                   | VERYSEVERE               |
|--------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Physical exhaustion (fatigue, lack of energy, stamina or motivation)                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep problems (difficulty falling asleep or sleeping through the night)                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Irritability (mood swings, feeling aggressive, angers easily)                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Decline in drive or interest (loss of "zest for life," feeling down or sad)                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulties with memory (concentration, finding the right word, or retaining information) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vaginal dryness or difficulty with sexual intercourse                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexual problems (change in desire, activity, orgasm and/or satisfaction)                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sweating (night sweats or increased episodes of sweating)                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hot flashes (burst that starts in chest and lasts for short duration)                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hair loss, thinning or change in texture of hair                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Feeling cold all the time, having cold hands or feet                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches or migraines (increase in frequency or intensity)                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight (difficulty losing weight despite diet/exercise)                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bladder problems (difficulty in urinating, increased need to urinate, incontinence)        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other symptoms or unique health circumstances to take into consideration:

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