Quest

Menopause Symptoms Tracker

Instructions:

Circle **"YES"** if you are currently experiencing or have experienced the listed symptom recently and describe the duration, frequency and severity of each in the corresponding text box. Circle **"NO"** if you are not experiencing the listed symptom.

Use this checklist, along with your lab results, to continue the conversation with your primary care physician.

Symptoms:	**Circle:**	**If "YES", describe duration, frequency, and/or severity:**
Irregular menstrual cycle	YES NO	
Hot flashes	YES NO	
Mood changes	YES NO	
Weight gain or bloating	YES NO	
Insomnia	YES NO	
Breast tenderness or pain	YES NO	
Depression	YES NO	
Headaches	YES NO	
Anxiety	YES NO	
Additional physical ailment	YES NO	
Other: _____	YES NO	