Female Health Assessment Questionaire

Name:____ Date:____________________

Check the appropriate box for each symptom you may be experiencing.

Symptoms	None	Mild	Moderate	Severe
Physical Exhaustion (fatigue, lack of energy, stamina, or motivation)				
Sleep Problems (difficulty falling asleep or sleeping through the night)				
Irritability (mood swings, feeling aggressive, anger easily)				
Anxiety (feeling overwhelmed, panicky, or nervous)				
Decline in drive or interest (Loss of "zest for life or feeling nervous)				
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)				
Difficulties with memory (concentration, finding the right word, or retaining information)				
Sexual Problems (change in desire, activity, orgasm, and/or satisfaction)				
Sweating (night sweats or increased episodes of sweating)				
Headaches or menstrual migraines (increase in frequency or intensity)				
Hot Flashes (burst that starts in chest and lasts for short duration)				
Bladder Problems (difficulty in urinating, increased need to urinate, incontinence)				
Vaginal dryness or difficulty with sexual intercourse				
Hair loss, thinning or change in texture of hair				
Weight (difficulty losing weight despite diet/exercise)				
Feeling cold all the time, having cold hands or feet				

Other symptoms or unique health circumstances to take into consideration:

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