The MenoScale

Name _____ Date _____

To what extent have you been bothered by [*symptom below*] as a symptom of menopause or perimenopause in the past week?

MENOPAUSAL SYMPTOMS	NOT AT ALL	A LITTLE	QUITE A BIT	EXTREMELY
Hot flushes				
Night sweats				
Loss of interest in sex				
Vaginal dryness				
Irritability				
Low mood, depression, mood swings				
Anxiety				
Palpitations (heart beating fast, strongly, or irregularly)				
Brain fog				
Memory problems				
Sleep problems				
Headaches				
Tiredness and fatigue				
Weight gain				
Decreased physical strength / stamina				
Digestive symptoms (e.g. bloating, gas, discomfort)				
Declining skin quality				
Declining hair quality				
Joint and muscular discomfort				
Bladder problems (e.g., infections, leaks, urgency)				
Total Score				

FOR RESEARCHER USE ONLY – SCORING:
NOT AT ALL = 0 | A LITTLE = 1 | QUITE A BIT = 3 | EXTREMELY = 5 | TOTAL SCORE RANGE: 0—100.

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