NAME:_____ Today's Date:_____

Menopause Rating Scale (MRS)

Which of the following symptoms apply to you **at this time**?

MARK ONE Box For EACH Symptom

	None	mild	moderate	severe	extremely severe
Score =	0	1	2	3	4
Symptoms:					
1. Hot flashes, sweating (episodes of sweating)	☐	☐	☐	☐	☐
2. Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
3. Sleep problems (difficulty in falling asleep, difficult in sleeping through the night, waking up early)	☐	☐	☐	☐	☐
4. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
5. Irritability (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
6. Anxiety (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
7. Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
8. Sexual problems (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
9. Bladder problems (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
10. Dryness of vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
11. Joint and muscular discomfort (pain in the joints, rheumatoid complaints)	☐	☐	☐	☐	☐
12. Breast tenderness	☐	☐	☐	☐	☐
13. Vaginal bleeding	☐	☐	☐	☐	☐
14. Migraines	☐	☐	☐	☐	☐
15. Voice changes	☐	☐	☐	☐	☐
16. Fluid Retention	☐	☐	☐	☐	☐
17. Facial hair	☐	☐	☐	☐	☐
18. Dry eye	☐	☐	☐	☐	☐

Baseline: _____No hormone therapy before

_____Hormone therapy (circle): Patch Drop Cream SL tabs Implant Oral

History of breast cancer: personal_____ family_____

Follow up:Last hormone appointment: _____

_____Hormone replacement by (circle): Patch Drop Cream SL tabs Implant Oral Vaginal Cream

_____Pellet implant therapy: Testosterone: _____ Estrogen: _____Weeks since implant_____

Pre-menopausal _____Post-menopausal _____Hysterectomy _____Ovaries removed_____