**Patient Name** ________________________________________ Date _______________

**Date of Birth** ____________ Age ___________

# Menopause Rating Scale (MRS)

Which of the following symptoms apply to you at this time? Mark the appropriate box for each symptom. For symptoms that do not apply, please mark 'None'.

| | Symptoms | None | Mild | Moderate | Severe | Extremely Severe |
|---|---|---|---|---|---|---|
| | Score = | | | | | |
| 1. | Hot flashes, sweating (episodes of sweating) | | | | | |
| 2. | Heart discomfort (unusual awareness of heartbeat, heart skipping, heart racing, tightness) | | | | | |
| 3. | Sleep problems (difficulty falling asleep, difficulty in sleeping through, 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, in satisfaction) | | | | | |
| 9. | Bladder problems (difficulty 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) | | | | | |

**Last Menstrual Cycle** _______________ **Last PAP** _____________ **Last Mammo** ________

**Number of Pregnancies:**_____ **Number of Live Births:** ______

**Y N** Weight gain, weight fluctuations **Y N** Hair changes, hair loss, change in hair texture

**Pre-menopause** ▢ **Post-Menopause** ▢ **Hysterectomy** ▢ **Ovaries Removed** ▢ **Ablation** ▢