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Menopause Symptom Tracker

Before talking to your doctor about starting HRT it will be helpful to identify the symptoms you have and what bothers you the most. Keep this page for reference in the future



	none	mild	moderate	severe	comments
Hot flushes					
Night sweats					
Poor quality sleep					
Tired, low energy					
Problems with memory					
Difficulty concentrating on tasks					
Low mood					
Anxiety or panic attacks					
Irritability					
Overwhelmed					
Loss of confidence					
Dry skin, itchiness or crawling sensations					
Headaches					
Racing heartbeat or palpitations					
Vaginal dryness					
Vaginal discharge					
Pain during sex					
Loss of libido or sex drive					
Frequent urinary tract infections					
Urge incontinence					
Muscle and joint pains					
Weight gain					
Other:					

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Menopause Symptom Tracker

After starting HRT, allow 6-8 weeks before considering how treatment has impacted your symptoms. Without referring back to the previous sheet, complete the symptom tracker below and record any new symptoms that may be related to HRT. If the HRT preparation or dose is changed then this checklist can be used again.



	none	mild	moderate	severe
Hot flushes				
Night sweats				
Poor quality sleep				
Tired, low energy				
Problems with memory				
Difficulty concentrating on tasks				
Low mood				
Anxiety or panic attacks				
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Vaginal discharge				
Pain during sex				
Loss of libido or sex drive				
Frequent urinary tract infections				
Urge incontinence				
Muscle and joint pains				
Weight gain				
Other:				

Record any new symptoms since starting HRT	
	Yes / No
Irreg. vaginal bleeding	
Bloating	
Breast tenderness	
Swelling	
Nausea	
Indigestion	
Leg cramps	
Headaches	
Mood swings	
Depression	
Acne	
Back pain	
Irreg. vaginal bleeding	
Bloating	
Breast tenderness	
Swelling	
Nausea	
Irreg. vaginal bleeding	
Bloating	
Breast tenderness	

Name..... Date of Birth.....

Landline Number Mobile number.....

Date you require your next supply of HRT.....

Blood pressure result: SYSTOLIC..... DIASTOLIC.....

Height:..... **Weight:**.....

Why do you take HRT? Early menopause (before aged 45) Menopausal symptoms

What date was your last period?.....

Have you had a Hysterectomy? Yes No

Have you had a Mirena coil(intrauterine system) fitted? Yes No

If yes, what date was your Mirena coil fitted?.....

Do you smoke? Yes No, per day..... No Ex-smoker Date stopped.....

How many units of alcohol do you drink per week? (Please circle)
Non-drinker 1-2 units 3-4 units 5-6 units 7-9 units 10+units

Have you ever had a heart attack or stroke? Yes No

Have you ever had any blood clots? (eg. Leg or Lung) Yes No

Have you ever had breast cancer or endometrial cancer? Yes No

Have you ever had liver or gallbladder disease? Yes No

Do you have any family history (parent or sibling) of any of the following? (Please circle all that apply)

Blood clots Breast cancer Endometrial cancer Heart attack Stroke

Are you currently using contraception? Yes No

Do you feel your HRT is effectively controlling your symptoms? Yes No

Have you been experiencing side effects since starting HRT? Yes No

Have you considered reducing or stopping your HRT? Yes No

Have you experienced any persistent unexpected bleeding, or increased bleeding? Yes No

Are you aware about the increased risk of blood clots and some cancers associated with HRT? Yes No

Are you up-to-date with your cervical screening (smear) and breast screening? Yes No

Do you regularly self-check your breasts? Yes No

Your Signature Date