
# Health Assessment For Women (Female Symptom Questionnaire)

**Name: Date: E-Mail Address:**

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark “never”.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Symptoms** | **Never (0)** | **Mild (1)** | **Moderate (2)** | **Severe (3)** | **Very Severe (4)** |
|  |  |  |  |  |  |
| Sweating (night sweats or increased episodes of sweating) |  |  |  |  |  |
|  |  |  |  |  |  |
| Depressive mood (feeling down, sad, on the verge of tears, lack of drive) |  |  |  |  |  |
| Irritability (mood swings, feeling aggressive, angers easily) |  |  |  |  |  |
| Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension) |  |  |  |  |  |
| Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation) |  |  |  |  |  |
| Sexual problems (change in sexual desire, in sexual activity and/or orgasm and satisfaction) |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise) |  |  |  |  |  |
|  |  |  |  |  |  |
| Problems with thinking, concentrating or reasoning |  |  |  |  |  |
|  |  |  |  |  |  |
| Trouble thinking of the right word to describe persons, places or things when speaking |  |  |  |  |  |
| Increase in frequency or intensity of headaches or migraines |  |  |  |  |  |
| Hair loss, thinning or change in texture of hair |  |  |  |  |  |
| Feel cold all the time or have cold hands or feet |  |  |  |  |  |
|  |  |  |  |  |  |
| Dry or wrinkled skin |  |  |  |  |  |
| **Total:** |  |

|  |  |
| --- | --- |
| **Severity** | **Score** |
| Mild | 1 - 20 |
| Moderate | 21 - 40 |
| Severe | 41 - 60 |
| Very Severe | 61 - 80 |

Female Health Assessment