

## Symptom Tracker and Goals

Use this worksheet before your consultation.

### Rate each symptom from 0 (none) to 10 (severe)

Hot flushes:	_____	0 1 2 3 4 5 6 7 8 9 10
Night sweats:	_____	0 1 2 3 4 5 6 7 8 9 10
Sleep quality:	_____	0 1 2 3 4 5 6 7 8 9 10
Mood changes:	_____	0 1 2 3 4 5 6 7 8 9 10
Anxiety:	_____	0 1 2 3 4 5 6 7 8 9 10
Energy levels:	_____	0 1 2 3 4 5 6 7 8 9 10
Brain fog:	_____	0 1 2 3 4 5 6 7 8 9 10
Libido:	_____	0 1 2 3 4 5 6 7 8 9 10
Muscle or joint aches:	_____	0 1 2 3 4 5 6 7 8 9 10
Weight changes:	_____	0 1 2 3 4 5 6 7 8 9 10

### Top 3 health goals for the next 3-6 months

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### Questions I want to discuss with my doctor

\_\_\_\_\_

\_\_\_\_\_

### Current medicines and supplements

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_