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MENOPAUSE RATING SCALE — MRS

LAST NAME	FIRST NAME	DATE OF BIRTH	TODAY'S DATE

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

X ONE Box For EACH Symptom – For symptoms that do not apply, please mark **none.**

Symptoms	Rating				
	none	mild	moderate	severe	extreme
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, difficulty 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 & 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.	☐	☐	☐	☐	☐
Score =	**0**	**1**	**2**	**3**	**4**

Do you have any other symptoms or concerns _____

Thank You for Your Cooperation