Perimenopause & Menopause Symptoms Questionnaire

Patient details

Name: Date of birth: Date:

Please tick one box per symptom based on the past 2–4 weeks.

Psychological & Emotional

	None	Mild	Moderate	Severe
Feeling tired or lacking in energy				
Difficulty sleeping				
Anxiety				
Low mood or feeling unhappy				
Tearfulness or crying spells				
Irritability				
Loss of interest in usual activities				
Loss of interest in sex				
Thoughts of harming yourself or suicide				

Cognitive

	None	Mild	Moderate	Severe
Memory problems				
Difficulty concentrating				
Low motivation				
Feeling overwhelmed				

Neurological & Sensory

	None	Mild	Moderate	Severe
Headaches or migraines				
Dizziness or feeling faint				
Pins and needles sensations				
Tinnitus (ringing in ears)				
Burning sensations (mouth, feet, skin)				

Digestive System

	None	Mild	Moderate	Severe
Weight gain or body changes				
Bloating				
Change in bowel habits				
Heartburn or reflux				

Skin, Hair & Eyes

	None	Mild	Moderate	Severe
Dry or itchy skin				
Hair thinning or hair loss				
Dry or irritated eyes				
Formication (crawling sensation)				

Genitourinary System

	None	Mild	Moderate	Severe
Frequent urination or night waking to urinate				
Urinary leakage				
Recurrent urinary infections				
Vaginal dryness or discomfort				
Pain with intercourse				

Heart, Lungs & Vasomotor

	None	Mild	Moderate	Severe
Hot flushes				
Night sweats				
Palpitations				
Breathing difficulty or snoring				

Musculoskeletal

	None	Mild	Moderate	Severe
Joint pain				
Muscle pain or stiffness				

Impact on You

Impact on work				
Impact at home				
Impact on relationships				
Overall impact on quality of life				

Menstrual Pattern

- No change – normal for me
- Changed (lighter, heavier or irregular)
- Stopped more than 12 months ago
- Unsure (e.g. contraception or hysterectomy)

This questionnaire supports discussion during your consultation and does not replace personalised medical advice.