Live Agelessly
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NAME:_____DATE OF BIRTH:_____TODAY'S DATE:_____

MENOPAUSE RATING SCALE (MRS)

Which of the following symptoms apply to you at this time? (***CHECK ONE BOX & CIRCLE APPLICABLE DESCRIPTION***).

Symptoms:	**Rating Scale:** **NONE**	**MILD**	**MODERATE**	**SEVERE**	**EXTREMELY SEVERE**
1) Hot Flashes:					
A. Episodes of Sweating B. Night Sweats……	☐	☐	☐	☐	☐
2) Heart Discomfort:					
A. Unusual Awareness of Heart Beat B. Heart Racing					
C. Tightness D. Heart Skipping……	☐	☐	☐	☐	☐
3) Sleep Problems:					
A. Difficulty In Sleeping Through The Night B. Waking Up Early	☐	☐	☐	☐	☐
4) Depressive Mood:					
A. Feeling Down B. Sad C. On The Verge Of Tears					
D. Lack of Drive E. Mood Swings……	☐	☐	☐	☐	☐
5) Irritability:					
A. Feeling Nervous B. Inner Tension					
C. Feeling Aggressive……	☐	☐	☐	☐	☐
6) Anxiety:					
A. Inner Restlessness/Anxious B. Panicky……	☐	☐	☐	☐	☐
7) Physical & Mental Exhaustion:					
A. General Decrease In Performance B. Impaired Memory					
C. Decrease in Concentration D. Brain Fog/Forgetfulness……	☐	☐	☐	☐	☐
8) Sexual Health:					
A. Lack Of Desire B. Change In Activity					
C. Change in Satisfaction……	☐	☐	☐	☐	☐
9) Vaginal Health:					
A. Dryness Of Vagina B. Difficulty With Intercourse					
C. Dryness Or Burning During Intercourse……	☐	☐	☐	☐	☐
10) Bladder Problems:					
A. Difficulty Urinating B. Increased Need To Urinate					
C. Bladder Incontinence……	☐	☐	☐	☐	☐
11) Musculoskeletal:					
A. Joint Discomfort/Pain B. Muscular Discomfort/Pain					
C. Rheumatoid Discomfort/Pain……	☐	☐	☐	☐	☐

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Please circle which applies to THIS questionnaire. **Baseline** or **Follow-Up**

Baseline ☐ No hormone Therapy ☐ Hormone Therapy (Other than Pellet Therapy) ☐

Testosterone Pellet Dose_____ Date Implanted_____

Additional Hormone Therapy_____ Date Started_____

Pre-Menopausal ☐ Post-Menopausal ☐ Partial Hysterectomy ☐ Total Hysterectomy ☐