Menopause Rating Scale (MRS) Name:_____ Date:_____

Which of the following symptoms apply to you at this time? Please, mark the appropriate box for each symptom. For symptoms that do not apply, please mark 'none'.

Symptoms:		none	mild	moderate	severe	very severe
	Score =	0	1	2	3	4
1. Hot Flashes, sweating……	Day :	☐	☐	☐	☐	☐
	Night:	☐	☐	☐	☐	☐
2. Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness)……..		☐	☐	☐	☐	☐
3. Sleep problems (difficulty falling asleep, difficulty in sleeping through, 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 and 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 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) ……		☐	☐	☐	☐	☐