MENOPAUSE CLINIC SYMPTOM QUESTIONNAIRE
(Greene Climacteric Scale)

Name: ______________________ **DOB:** __________ **Date:** __________

Please indicate the extent to which you are bothered at the moment by any of these symptoms by placing a tick in the appropriate box:

	Symptoms	Not at all 0	A little 1	Quite a bit 2	Extremely 3	Comments
1	Heart beating quickly or strongly					
2	Feeling tense or nervous					
3	Difficulty sleeping					
4	Excitable					
5	Attacks of anxiety, panic					
6	Difficulty concentrating					
7	Feeling tired or lacking in energy					
8	Loss of interest in most things					
9	Feeling unhappy or depressed					
10	Crying spells					
11	Irritability					
12	Feeling dizzy or faint					
13	Pressure or tightness in head					
14	Parts of body feel numb					
15	Headaches					
16	Muscles and joint pain					
17	Loss of feeling in hands or feet					
18	Breathing difficulties					
19	Hot flushes					
20	Night sweats					
21	Loss of interest in sex					
(for internal use only)	**SCORE:**					