2009-029 EVE1-FMR-CT
Menopause Rating Scale (MRS)

SUBJECT:_____**VISIT: S 1 2 3 4**

VISIT 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'.
Please use blue or black ink to check the appropriate box

Symptoms:	**None**	**Mild**	**Moderate**	**Severe**	**Very Severe**	**Office Use Only**
Score =	**0**	**1**	**2**	**3**	**4**	
1. Hot flushes, 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, 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 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)	☐	☐	☐	☐	☐	
					TOTAL	
					4 THRU 7	
					1 THRU 3 + 11	
					8 THRU 10	