Vitality Clinic
MENOPAUSE & WELLNESS

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Modified Greene Climacteric Scale

Name _____

Date _____

Over the last month, to what extent are you experiencing the following symptoms:

Symptoms	Not at all (0)	Occasionally (1)	Frequently (2)	Comment
Awareness of heart beat/palpitations				
Feeling tense/nervous				
Sleep difficulties				
Excitability				
Anxiety/panic attacks				
Difficulty concentrating/memory issues				
Fatigue/lack of energy				
Loss of enjoyment/interest in things				
Feeling depressed or unhappy				
Frequent crying				
Irritability / low mood				
Dizziness / feeling faint				
Pressure / tightness in the head				
Parts of the body feeling numb (eg: hands and feet)				
Headaches				
Muscle / joint pains				
Hot flushes				
Night sweats				
Loss of interest in or painful sex				
Dry vagina				
Muscle twitches/sensation of skin crawling				
SCORE				

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What effect are your symptoms having on your quality of life?

_____

_____

_____

If your symptoms were continue as they are now for some time to come, how would you feel about that?

- Pleased
- Mostly satisfied
- Mixed - equally satisfied / dissatisfied
- Mostly dissatisfied
- Quite unhappy