

# Green climacteric scale

Name: \_\_\_\_\_

Date: \_\_\_\_\_

The Greene Scale provides a brief measure of menopause symptoms. It can be used to assess changes in different symptoms, before and after menopause treatment. Please rate the extent to which you are bothered recently by any of these symptoms. Write the number in the 'rating' column.

0=never

1= a little

2 = quite often

3 = all the time

|    | Symptom  | Rating (0-3) |
|----|--|--------------|
| 1  | Do you ever feel your heart beating quickly or pounding?                           |              |
| 2  | Do you feel tense or nervous??   |              |
| 3  | Do you have difficulty sleeping? Either getting to sleep or waking up in the night |              |
| 4  | Do you often feel excitable?   |              |
| 5  | Are you anxious or experiencing panic attacks?                                     |              |
| 6  | Do you have difficulty concentrating?  |              |
| 7  | Are you tired or lacking in energy during the day?                                 |              |
| 8  | Have you experienced a lack of interest in things and activities?                  |              |
| 9  | Do you often feel unhappy or depressed?  |              |
| 10 | Are you experiencing crying spells in your day to day life?                        |              |
| 11 | Are you irritable with your family, friends and people you come into contact with? |              |
| 12 | Do you feel dizzy or faint?  |              |
| 13 | Do you ever feel pressure or a tightness in your head?                             |              |
| 14 | Do parts of your body feel numb?   |              |
| 15 | Are you experiencing headaches?  |              |
| 16 | Do you feel pains or aches in your muscles and joints?                             |              |
| 17 | Do you ever experience a loss of feeling or numbness in your hands and feet?       |              |
| 18 | Do you ever have difficulty breathing?   |              |
| 19 | Are you experiencing hot flushes?  |              |
| 20 | Do you sweat in the night?   |              |
| 21 | Has your libido changed? Have you lost interest in sex?                            |              |
|    | <b>TOTAL:</b>  |              |

