



Menopause Wellness Planner

Digital Edition — Your Guide Through Every Stage

Track symptoms • Monitor patterns • Reclaim your wellbeing

Name: _____ Start Date: _____

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Journey Overview

Stage, goals & checklist

Hot Flash Tracker

Time, triggers & relief

Medications

Rx, supplements & HRT

Symptom Tracker

Weekly symptom checklist

Sleep Log

Quality & pattern tracking

Doctor Notes

Pre-visit prep & notes

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Daily tracking for 6 months

Mood Tracker

AM/PM mood & energy

Self-Care Planner

Weekly wellness grid

My Menopause Journey Overview

My Stage

- ☐ Perimenopause (irregular periods beginning)
- ☐ Menopause (12+ months without period)
- ☐ Post-Menopause
- ☐ Surgical Menopause
- ☐ Unsure / In Transition

Start Date: Age:

Last Period:

Healthcare Provider:

My Top Symptoms

- ☐ Hot flashes / night sweats
- ☐ Sleep disruption
- ☐ Mood changes / anxiety
- ☐ Brain fog / memory
- ☐ Weight changes
- ☐ Joint pain
- ☐ Fatigue / low energy
- ☐ Vaginal dryness
- ☐ Heart palpitations
- ☐ Headaches
- ☐ Hair / skin changes
- ☐ Other:

My Wellness Goals

Physical

Emotional

Lifestyle

Current Treatments & Support

HRT / Medications:

Exercise Routine:

Supplements:

Support Network:

Weekly Symptom Tracker

Check each symptom experienced daily. Week of: _____

Symptom	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain Fog	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Libido	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair Thinning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes & Patterns Observed

Monthly Log

Month 1

Month: _____ Year: _____

Day	Hot Flashes	Night Sweats	Sleep 1-5	Mood 1-5	Energy 1-5	Exercise	Notes
1							
2							
3							
4							
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31							

Month: _____ Year: _____

Day	Hot Flashes	Night Sweats	Sleep 1-5	Mood 1-5	Energy 1-5	Exercise	Notes
1							
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31							

Monthly Log

Month: _____ Year: _____

Day	Hot Flashes	Night Sweats	Sleep 1-5	Mood 1-5	Energy 1-5	Exercise	Notes
1							
2							
3							
4							
5							
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Month: _____ Year: _____

Day	Hot Flashes	Night Sweats	Sleep 1-5	Mood 1-5	Energy 1-5	Exercise	Notes
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Month: _____ Year: _____

Day	Hot Flashes	Night Sweats	Sleep 1-5	Mood 1-5	Energy 1-5	Exercise	Notes
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31							

Monthly Log

Month: _____ Year: _____

Day	Hot Flashes	Night Sweats	Sleep 1-5	Mood 1-5	Energy 1-5	Exercise	Notes
1							
2							
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4							
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Hot Flash Tracker

Date Range: _____ to _____

[illegible]

Common Triggers Checklist

- ☐ Stress
 ☐ Caffeine
 ☐ Hot environment
 ☐ Tight clothing
☐ Spicy food
 ☐ Alcohol
 ☐ Exercise
 ☐ Sugar

Hot Flash Tracker

Date Range: _____ to _____

[illegible]

Patterns Noticed

Hot Flash Tracker

Date Range: _____ to _____

[illegible]

Patterns Noticed

Nav **Sleep Log**

Symptoms Dates: _____ to _____

	Date	Bedtime	Wake Time	Hours	Night Sweats	Quality 1-5	Notes (wakeups, dreams, aids used)
Mon 1							
Mon 2							
Mon 3							
Mon 4							
Mon 5							
Mon 6							
HF 1							

Sleep Hygiene Checklist

- ☐ Cool bedroom (65-68F)
 - ☐ No caffeine after 2pm
 - ☐ Relaxation routine
 - ☐ No screens 1hr before
 - ☐ Consistent bedtime
 - ☐ Moisture-wicking PJs

Sleep Log

Dates: _____ to _____

[illegible]

Sleep Patterns & Insights

Mood & Energy Tracker

Week of: _____

Day	AM		PM		Triggers	Coping Strategy Used
	Mood 1-5	Energy 1-5	Mood 1-5	Energy 1-5		
Mon						
Tue						
Wed						
Thu						
Fri						
Sat						
Sun						

Mood Scale Reference

- 1 = Very low / depressed / overwhelmed
- 2 = Low / anxious / irritable
- 3 = Neutral / okay / manageable
- 4 = Good / calm / positive
- 5 = Great / joyful / balanced

My Coping Toolkit

- ☐ Deep breathing
- ☐ Walk / movement
- ☐ Journaling
- ☐ Talk to friend
- ☐ Meditation
- ☐ Creative activity
- ☐ Limit caffeine
- ☐ Nature time

Weekly Reflection

Best day & why:

Most challenging:

What helped most:

Medications, Supplements & HRT

Name	Dose	Frequency	Time	Purpose	Side Effects	Start Date

HRT Details

Type:

Started:

Provider:

Next review:

Notes:

Supplements Tried

- ☐ Black Cohosh
- ☐ Evening Primrose Oil
- ☐ Magnesium
- ☐ Vitamin D
- ☐ Ashwagandha
- ☐ Omega-3
- ☐ Maca Root
- ☐ Probiotics
- ☐ Red Clover
- ☐ Calcium

Doctor Visit Notes

Appointment Details

Date:

Doctor:

Type: ☐ Annual ☐ Follow-up ☐ Specialist ☐ Urgent

Pre-Visit Checklist

- ☐ Updated symptom tracker
- ☐ List of current medications
- ☐ Written questions ready
- ☐ Insurance card
- ☐ Previous lab results
- ☐ Symptom diary/photos
- ☐ Family history notes

Questions to Ask

1.

2.

3.

4.

5.

6.

7.

8.

Doctor's Notes & Recommendations

Tests Ordered

- ☐ Blood work (hormones)
- ☐ Thyroid panel
- ☐ Bone density (DEXA)
- ☐ Mammogram
- ☐ Pap smear
- ☐ Cholesterol panel
- ☐ Vitamin D levels
- ☐ Other:

Follow-Up

Next appt:

Action items:

Self-Care Weekly Planner

Week of: _____

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Body							
Mind							
Spirit							
Social							

Body Ideas

- Walk / yoga
- Strength training
- Epsom salt bath
- Stretching
- Healthy meal prep
- Hydration goal

Mind Ideas

- Meditation
- Journaling
- Read a book
- Brain puzzle
- Learn something
- Digital detox

Spirit Ideas

- Gratitude list
- Nature walk
- Prayer / reflection
- Creative art
- Music therapy
- Affirmations

Social Ideas

- Call a friend
- Support group
- Date night
- Volunteer
- Coffee meetup
- Set boundaries

Weekly Self-Care Wins & Reflections

What nourished me:

What I need more of:

Next week's intention: