

# Menopause Symptom Tracker

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Track your symptoms, identify triggers,  
and take control of your menopause journey.

A daily tracking system to help you  
and your doctor find what works for YOU.

## FREE RESOURCE

from The Menopause Planner | [menopauseplanner.com](https://menopauseplanner.com)

# Welcome to Your Tracker

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You're not imagining it. The hot flashes at 3pm, the insomnia at 2am, the brain fog that makes you forget why you walked into a room -- these are real symptoms with real triggers. And the first step to managing them is understanding YOUR unique patterns.

This tracker is designed to help you connect the dots between what you eat, how you sleep, your stress levels, and the intensity of your symptoms. After just 2-4 weeks of consistent tracking, most women discover surprising patterns they never noticed before.

## How to Use This Tracker:

1

### Track daily (it takes 2 minutes)

Fill in your symptom tracker each evening before bed. Rate each symptom 0-5 where 0 = none and 5 = severe.

2

### Log your food triggers

Use the Food & Sugar Trigger Log to note what you ate, especially sugar, caffeine, and alcohol. Look for patterns 4-8 hours after consumption.

3

### Note your sleep quality

Poor sleep amplifies every other symptom. The sleep tracker helps you identify what's disrupting your rest.

4

### Review weekly

At the end of each week, look at your patterns. Do hot flashes spike on high-sugar days? Does exercise improve your mood scores?

5

### Bring it to your doctor

Your completed tracker gives your healthcare provider actual data instead of vague descriptions. This leads to better, personalized treatment.

## PRO TIP

Research shows that sugar spikes can trigger hot flashes within 2-4 hours. Pay special attention to the food log -- it's often the most revealing section.



# My Baseline Assessment

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Before you start tracking, take a snapshot of where you are right now. Check all symptoms you currently experience and rate their severity (1=mild, 5=severe). Revisit this page in 30 days to see how things have changed.

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_

## VASOMOTOR SYMPTOMS

- |  |                     |
|--|---------------------|
| <input type="checkbox"/> Hot flashes (daytime)     | Severity: 1 2 3 4 5 |
| <input type="checkbox"/> Night sweats              | Severity: 1 2 3 4 5 |
| <input type="checkbox"/> Heart palpitations        | Severity: 1 2 3 4 5 |
| <input type="checkbox"/> Flushing / facial redness | Severity: 1 2 3 4 5 |

## MOOD & COGNITIVE

- |   |                     |
|---|---------------------|
| <input type="checkbox"/> Anxiety or panic attacks       | Severity: 1 2 3 4 5 |
| <input type="checkbox"/> Irritability / mood swings     | Severity: 1 2 3 4 5 |
| <input type="checkbox"/> Brain fog / poor concentration | Severity: 1 2 3 4 5 |
| <input type="checkbox"/> Memory lapses                  | Severity: 1 2 3 4 5 |
| <input type="checkbox"/> Feeling overwhelmed            | Severity: 1 2 3 4 5 |
| <input type="checkbox"/> Low mood / sadness             | Severity: 1 2 3 4 5 |

## SLEEP

- |  |                     |
|--|---------------------|
| <input type="checkbox"/> Difficulty falling asleep | Severity: 1 2 3 4 5 |
| <input type="checkbox"/> Waking at 2-4 AM          | Severity: 1 2 3 4 5 |
| <input type="checkbox"/> Restless / light sleep    | Severity: 1 2 3 4 5 |
| <input type="checkbox"/> Daytime fatigue           | Severity: 1 2 3 4 5 |

## PHYSICAL

- |  |                     |
|--|---------------------|
| <input type="checkbox"/> Joint or muscle pain                | Severity: 1 2 3 4 5 |
| <input type="checkbox"/> Weight gain (especially midsection) | Severity: 1 2 3 4 5 |
| <input type="checkbox"/> Headaches / migraines               | Severity: 1 2 3 4 5 |
| <input type="checkbox"/> Bloating / digestive changes        | Severity: 1 2 3 4 5 |
| <input type="checkbox"/> Hair thinning                       | Severity: 1 2 3 4 5 |
| <input type="checkbox"/> Dry skin / itching                  | Severity: 1 2 3 4 5 |

## OTHER

- |   |                     |
|---|---------------------|
| <input type="checkbox"/> Vaginal dryness      | Severity: 1 2 3 4 5 |
| <input type="checkbox"/> Low libido           | Severity: 1 2 3 4 5 |
| <input type="checkbox"/> Urinary urgency      | Severity: 1 2 3 4 5 |
| <input type="checkbox"/> Tingling extremities | Severity: 1 2 3 4 5 |



# Week 1 -- Daily Symptom Tracker

Rate each symptom 0-5 (0 = none, 5 = severe). Track at the same time each day for consistency.

Week starting: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

| SYMPTOM        | Mon | Tue | Wed | Thu | Fri | Sat | Sun |
|----------------|-----|-----|-----|-----|-----|-----|-----|
| Hot flashes    |     |     |     |     |     |     |     |
| Night sweats   |     |     |     |     |     |     |     |
| Mood (low=bad) |     |     |     |     |     |     |     |
| Anxiety level  |     |     |     |     |     |     |     |
| Brain fog      |     |     |     |     |     |     |     |
| Energy level   |     |     |     |     |     |     |     |
| Sleep quality  |     |     |     |     |     |     |     |
| Joint pain     |     |     |     |     |     |     |     |
| Headache       |     |     |     |     |     |     |     |
| Bloating       |     |     |     |     |     |     |     |
| Irritability   |     |     |     |     |     |     |     |
| Weight (lbs)   |     |     |     |     |     |     |     |

## WEEKLY NOTES & OBSERVATIONS

**PATTERN CHECK:**

Worst symptom day: \_\_\_\_\_ Best day: \_\_\_\_\_ Possible trigger: \_\_\_\_\_



# Week 2 -- Daily Symptom Tracker

Rate each symptom 0-5 (0 = none, 5 = severe). Track at the same time each day for consistency.

Week starting: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

| SYMPTOM        | Mon | Tue | Wed | Thu | Fri | Sat | Sun |
|----------------|-----|-----|-----|-----|-----|-----|-----|
| Hot flashes    |     |     |     |     |     |     |     |
| Night sweats   |     |     |     |     |     |     |     |
| Mood (low=bad) |     |     |     |     |     |     |     |
| Anxiety level  |     |     |     |     |     |     |     |
| Brain fog      |     |     |     |     |     |     |     |
| Energy level   |     |     |     |     |     |     |     |
| Sleep quality  |     |     |     |     |     |     |     |
| Joint pain     |     |     |     |     |     |     |     |
| Headache       |     |     |     |     |     |     |     |
| Bloating       |     |     |     |     |     |     |     |
| Irritability   |     |     |     |     |     |     |     |
| Weight (lbs)   |     |     |     |     |     |     |     |

## WEEKLY NOTES & OBSERVATIONS

**PATTERN CHECK:**

Worst symptom day: \_\_\_\_\_ Best day: \_\_\_\_\_ Possible trigger: \_\_\_\_\_





# Week 3 -- Daily Symptom Tracker

Rate each symptom 0-5 (0 = none, 5 = severe). Track at the same time each day for consistency.

Week starting: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

| SYMPTOM        | Mon | Tue | Wed | Thu | Fri | Sat | Sun |
|----------------|-----|-----|-----|-----|-----|-----|-----|
| Hot flashes    |     |     |     |     |     |     |     |
| Night sweats   |     |     |     |     |     |     |     |
| Mood (low=bad) |     |     |     |     |     |     |     |
| Anxiety level  |     |     |     |     |     |     |     |
| Brain fog      |     |     |     |     |     |     |     |
| Energy level   |     |     |     |     |     |     |     |
| Sleep quality  |     |     |     |     |     |     |     |
| Joint pain     |     |     |     |     |     |     |     |
| Headache       |     |     |     |     |     |     |     |
| Bloating       |     |     |     |     |     |     |     |
| Irritability   |     |     |     |     |     |     |     |
| Weight (lbs)   |     |     |     |     |     |     |     |

## WEEKLY NOTES & OBSERVATIONS

**PATTERN CHECK:**

Worst symptom day: \_\_\_\_\_ Best day: \_\_\_\_\_ Possible trigger: \_\_\_\_\_



# Week 4 -- Daily Symptom Tracker

Rate each symptom 0-5 (0 = none, 5 = severe). Track at the same time each day for consistency.

Week starting: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

| SYMPTOM        | Mon | Tue | Wed | Thu | Fri | Sat | Sun |
|----------------|-----|-----|-----|-----|-----|-----|-----|
| Hot flashes    |     |     |     |     |     |     |     |
| Night sweats   |     |     |     |     |     |     |     |
| Mood (low=bad) |     |     |     |     |     |     |     |
| Anxiety level  |     |     |     |     |     |     |     |
| Brain fog      |     |     |     |     |     |     |     |
| Energy level   |     |     |     |     |     |     |     |
| Sleep quality  |     |     |     |     |     |     |     |
| Joint pain     |     |     |     |     |     |     |     |
| Headache       |     |     |     |     |     |     |     |
| Bloating       |     |     |     |     |     |     |     |
| Irritability   |     |     |     |     |     |     |     |
| Weight (lbs)   |     |     |     |     |     |     |     |

## WEEKLY NOTES & OBSERVATIONS

**PATTERN CHECK:**

Worst symptom day: \_\_\_\_\_ Best day: \_\_\_\_\_ Possible trigger: \_\_\_\_\_



## Food & Sugar Trigger Log

Log meals, snacks, and drinks -- especially sugar, caffeine, and alcohol. Note any symptoms within 2-8 hours. This is often the most eye-opening page.

[illegible]

### COMMON HIDDEN SUGAR SOURCES TO WATCH FOR:

Yogurt (flavored), granola bars, smoothies, salad dressing, pasta sauce, bread, dried fruit, 'healthy' cereals, oat milk (sweetened),

protein bars, condiments (ketchup, BBQ sauce), fruit juice, flavored coffee drinks





## Food & Sugar Trigger Log (continued)

Log meals, snacks, and drinks -- especially sugar, caffeine, and alcohol. Note any symptoms within 2-8 hours. This is often the most eye-opening page.

[illegible]

### COMMON HIDDEN SUGAR SOURCES TO WATCH FOR:

Yogurt (flavored), granola bars, smoothies, salad dressing, pasta sauce, bread, dried fruit, 'healthy' cereals, oat milk (sweetened),

protein bars, condiments (ketchup, BBQ sauce), fruit juice, flavored coffee drinks



# Sleep Quality Tracker

Sleep disruption affects 60% of menopausal women. Tracking your sleep patterns helps identify whether sugar, caffeine, screen time, or hormonal shifts are the primary cause of your insomnia.

| DATE | BEDTIME | WAKE TIME | HOURS | QUALITY<br>(1-5) | NIGHT<br>SWEATS | WOKE UP<br>AT | NOTES / POSSIBLE CAUSE |
|------|---------|-----------|-------|------------------|-----------------|---------------|------------------------|
|      |         |           |       |                  |                 |               |                        |
|      |         |           |       |                  |                 |               |                        |
|      |         |           |       |                  |                 |               |                        |
|      |         |           |       |                  |                 |               |                        |
|      |         |           |       |                  |                 |               |                        |
|      |         |           |       |                  |                 |               |                        |
|      |         |           |       |                  |                 |               |                        |
|      |         |           |       |                  |                 |               |                        |
|      |         |           |       |                  |                 |               |                        |
|      |         |           |       |                  |                 |               |                        |
|      |         |           |       |                  |                 |               |                        |
|      |         |           |       |                  |                 |               |                        |
|      |         |           |       |                  |                 |               |                        |
|      |         |           |       |                  |                 |               |                        |
|      |         |           |       |                  |                 |               |                        |
|      |         |           |       |                  |                 |               |                        |
|      |         |           |       |                  |                 |               |                        |

**SLEEP HYGIENE QUICK WINS:**

No caffeine after 12pm | No sugar 4hrs before bed | Cool room (65-68F) | No screens 1hr before | Magnesium glycinate at bedtime



# Doctor Visit Prep Worksheet

Bring this page to your next appointment. Having organized data helps your doctor give you better, more personalized advice. Studies show patients who bring symptom logs get more thorough consultations.

**Appointment Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Doctor:** \_\_\_\_\_

## MY TOP 3 CONCERNS RIGHT NOW

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## CURRENT MEDICATIONS & SUPPLEMENTS

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Since: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Since: \_\_\_\_\_

Supplement: \_\_\_\_\_ Dose: \_\_\_\_\_ Since: \_\_\_\_\_

Supplement: \_\_\_\_\_ Dose: \_\_\_\_\_ Since: \_\_\_\_\_

## QUESTIONS I WANT TO ASK

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## SYMPTOM SUMMARY (from your tracking data)

Most frequent symptom: \_\_\_\_\_ Avg severity: \_\_\_\_/5

Biggest identified trigger: \_\_\_\_\_

Best symptom-free days were when I: \_\_\_\_\_

Sleep average: \_\_\_\_\_ hours/night Worst nights: \_\_\_\_\_

## QUESTIONS YOU MIGHT NOT THINK TO ASK:

- ☐ Should I get my hormone levels tested? If so, which ones and when in my cycle?
- ☐ Is HRT appropriate for me given my health history?
- ☐ Could my symptoms be related to thyroid function?
- ☐ What lifestyle changes would make the biggest difference for MY specific symptoms?
- ☐

Are there any supplements that are evidence-based for my main complaints?





# Monthly Patterns Summary

After 4 weeks of tracking, fill in this summary page. This is your roadmap -- it shows you exactly what's working and what isn't. Many women find this single page more valuable than the entire tracker.

Month: \_\_\_\_\_ Year: \_\_\_\_\_

## TOP 3 SYMPTOMS THIS MONTH

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## CONFIRMED TRIGGERS (things that made symptoms worse)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## CONFIRMED HELPERS (things that improved symptoms)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## PATTERNS I NOTICED

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## MONTH-OVER-MONTH COMPARISON

Overall symptom severity: Much Worse / Worse / Same / Better / Much Better  
Sleep quality: Much Worse / Worse / Same / Better / Much Better  
Energy levels: Much Worse / Worse / Same / Better / Much Better

## GOALS FOR NEXT MONTH:

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# Enjoying This Tracker?

This free tracker is just one piece of the puzzle. The full Menopause Wellness Planner Bundle includes 34 pages of comprehensive tools designed to help you take complete control of your menopause journey.

## Everything in this free tracker PLUS:

- 34 beautifully designed printable pages
- Digital version for GoodNotes & Notability
- HRT tracking & medication schedules
- Comprehensive food & nutrition planner
- Exercise & movement tracker
- Mood journal with guided prompts
- Medical appointment organizer
- Monthly & quarterly review templates
- Goal setting & habit tracker worksheets

## Get the Full Planner Bundle

[etsy.com/listing/4435219468](https://etsy.com/listing/4435219468)

The Menopause Planner  
Real information. No fear. Just clarity.

[menopause-planner-website.vercel.app](https://menopause-planner-website.vercel.app)