



Menopause is a normal event in a woman's life and is marked by the end of menstrual periods. Usually during the 40s, a gradual process leading to menopause begins. This is called the menopause transition or perimenopause. Changes in the pattern of menstrual periods are very common during this stage. Sometimes a woman can have other symptoms too, and these symptoms may extend beyond menopause. Even if a woman has no symptoms, it's important for her to understand the effects of menopause on her health.

This questionnaire is intended to help you inform your healthcare provider about your menopause experience and your general health. Working together, you can develop a plan to support your health, not only now but also in years to come. If you feel uncomfortable answering any of the questions on this form, you may wait and discuss them with your healthcare provider.

SECTION 1- TODAY'S OFFICE VISIT

Date: _____

Name: _____ Date of birth: _____

Why are you here today?

What are your main concerns or questions you would like to have answered during your visit?

Who referred you?

SECTION 2- HEIGHT & WEIGHT INFORMATION

What is your maximum remembered height? _____

How old were you then? _____

What is your maximum remembered weight? _____

How old were you then? _____

What is your lowest remembered weight as an adult? _____

How old were you then? _____

SECTION 3- GYNECOLOGIC HISTORY

How would you describe your current menstrual status?

- Premenopause (before menopause; having regular periods)
- Perimenopause/menopause transition (changes in periods, but have not gone 12 months in a row without a period)
- Postmenopause (after menopause)

Was your menopause:

- Spontaneous ("natural")
- Surgical (removal of both ovaries)
- Due to chemotherapy or radiation therapy; reason for therapy: _____
- Other (explain): _____

Age at first menstrual period: _____

Are your periods (or were your periods) usually regular? Yes No

If not still having periods, what was your age when you had your last period? _____

If still having periods, how often do they occur? _____

How many days does your period last? _____

Are your periods painful? Yes No

If yes, how painful? Mild Moderate Severe

Do you have spotting or bleeding between periods? Yes No

Has your period recently become very heavy? Yes No

Do you think you have a problem with your period? Yes No

If yes, explain: _____

Do you have any problems with PMS? (PMS is having mood swings, bloating, headaches, etc. prior to your period) Yes No

SECTION 4: SEXUAL HISTORY

Are you currently sexually active? Yes No

If yes, are you currently having sex with: A man/men A woman/women Both men & women

How long have you been with your current sex partner? _____

Are you in a committed, mutually monogamous relationship? Yes No

Do you have concerns about your sex life? Yes No

Do you have a loss of interest in sexual activities (libido, desire)? Yes No

Do you have a loss of arousal (tingling in the genitals or breast; vaginal moisture, warmth)? Yes No

Do you have a loss of response (weaker or absent orgasm)? Yes No

Do you have any pain with intercourse (vaginal penetration)? Yes No

If yes, how long ago did the pain start? _____

Please describe the pain: Pain with penetration Pain inside Feels dry

SECTION 5: MEDICATION HISTORY

Are you currently using hormone therapy for menopause? Yes No

If yes, for what reasons? _____

SECTION 6: FAMILY HISTORY

Please list family member (ie, mother, father, sister, brother, grandparent, aunt, uncle) who currently has or once had the following:

High blood pressure:	Colorectal cancer:
Heart attack (indicate age):	Ovarian cancer:
Stroke (indicate age):	Other cancer:
Blood problems:	Depression:
Blood clots:	Other emotional problems:
Bleeding tendency:	Alzheimer's disease:
Glaucoma:	Alcoholism:
Osteoporosis:	Drug abuse:
Hip fracture:	
Diabetes:	
Breast cancer (indicate age):	

Is there anything about your family's health history that concerns you, or that you would like to discuss? Yes No If yes, what? _____

SECTION 11: PERSONAL HABITS

Do you consider your health to be: Excellent Good Fair Poor

Exercise

How often do you exercise? Almost daily At least 3xweek Occasionally Rarely Never

If you exercise, what do you do?

For how long and how often?

Diet

How many meals do you consume each day?

Do you try to eat a special diet? Low-fat Low carbohydrate High protein Vegetarian

What dairy products do you consume each day?

Milk How much? _____ Yogurt How much? _____

Cheese How much? _____ Other _____

Are you lactose intolerant (diarrhea or gastrointestinal upset after dairy products)? Yes No

How many servings of fruits do you consume each day?

How many servings of vegetables do you consume each day?

How many servings of soy foods do you consume each week?

How many servings of fish do you consume each week?

Tobacco use

Do you currently smoke cigarettes? Yes No

If yes, how many per day? _____ When did you start? _____

How do you feel about quitting smoking? _____

If you do not currently smoke cigarettes, have you ever smoked? Yes No

If yes, when did you start? _____ How many per day? _____ When did you stop? _____

Do you use any other type of tobacco? Yes No If yes, what? _____

Caffeine use

Do you consume drinks with caffeine (coffee, tea, soda drinks)? Yes No

If yes, how many drinks each day? _____

Alcohol and drug use

Do you drink alcohol? Yes No

If yes, how many drinks do you have each week? _____

Do you ever have a drink in the morning to get you going? Yes No

Have you ever tried to cut down on your drinking? Yes No

Have you ever felt guilty about the amount you drink? Yes No

Have you ever been an alcoholic? Yes No

Do you use illegal drugs? Yes No

Abuse

Within the last year, have you been hit, slapped, kicked, or physically hurt by someone? Yes No

Within the last year, has anyone ever forced you to have sexual activities? Yes No

Do you feel you are verbally or emotionally abused by someone? Yes No

Have you had counseling for these issues? Yes No

Stress management

What are the current major stressors or life changes in your life? _____

Any major changes in the family health during the past year? Yes No

If yes, explain: _____

How do you handle stress? Very well Moderately well Poorly

What do you do to relax? _____

SECTION 12: SYMPTOMS

Please indicate how bothered you are now and in the past few weeks by any of the following:

	Not at all	A little bit	Quite a bit	Extremely
I have hot flashes	[]	[]	[]	[]
I have night sweats	[]	[]	[]	[]
I have difficulty getting to sleep	[]	[]	[]	[]
I have difficulty staying asleep	[]	[]	[]	[]
I get heart palpitations or a fluttering sensation in my chest or stomach	[]	[]	[]	[]
I feel like my skin is crawling or itching	[]	[]	[]	[]
I feel more tired than usual	[]	[]	[]	[]
I have difficulty concentrating	[]	[]	[]	[]
My memory is poor	[]	[]	[]	[]
I am more irritable than usual	[]	[]	[]	[]
I feel more anxious than usual	[]	[]	[]	[]
I have more depressed moods	[]	[]	[]	[]
I am having mood swings	[]	[]	[]	[]
I have crying spells	[]	[]	[]	[]
I have headaches	[]	[]	[]	[]
I need to urinate more often than usual	[]	[]	[]	[]
I leak urine	[]	[]	[]	[]
I have pain or burning when urinating	[]	[]	[]	[]
I have bladder infections	[]	[]	[]	[]
I have uncontrollable loss of stool or gas	[]	[]	[]	[]
My vagina is dry	[]	[]	[]	[]
I have vaginal itching	[]	[]	[]	[]
I have an abnormal vaginal discharge	[]	[]	[]	[]
I have vaginal infections	[]	[]	[]	[]
I have pain during intercourse	[]	[]	[]	[]
I have pain inside during intercourse	[]	[]	[]	[]
I have bleeding after intercourse	[]	[]	[]	[]
I lack desire or interest in sexual activity	[]	[]	[]	[]
I have difficulty achieving orgasm	[]	[]	[]	[]
My opportunity for sexual activity is limited	[]	[]	[]	[]
My stomach feels like it's bloated or I've gained weight	[]	[]	[]	[]
I have breast tenderness	[]	[]	[]	[]
I have joint pains	[]	[]	[]	[]