



## Menopause Health Questionnaire

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. PERSONAL INFORMATION

Date:					
Name:					
Address:					
Telephone number (home):			Telephone number (work):		
Telephone number (cell):			Birth date:		Age:
Ethnic/cultural background (please check what applies to you):					
<input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Biracial <input type="checkbox"/> Hispanic/Latina <input type="checkbox"/> Other (please specify)					
Marital status (circle):      Single      Married      Divorced      Widowed      Committed relationship					
Name of primary support person:					
Relationship:					
Primary support person telephone number:					
Employment status (circle):      Unemployed      Employed      Retired      Disabled					
If employed, occupation:					
Are you on medical leave: <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, why?					For how long?
Who is your primary healthcare provider?					
Address:			Telephone number:		

### Section 2. TODAY'S OFFICE VISIT

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 3. HEIGHT AND WEIGHT INFORMATION**

What is your height?	
What is your maximum remembered height?	How old were you then?
What is your weight?	
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 4. MEDICAL HISTORY**

*Please check if you have had problems with:*

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Migraines                   | <input type="checkbox"/> Colitis                         | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Fatigue             |
| <input type="checkbox"/> Blood Pressure              | <input type="checkbox"/> Diarrhea                        | <input type="checkbox"/> Thyroid              | <input type="checkbox"/> Sleeping            |
| <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Constipation                    | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Dizziness           |
| <input type="checkbox"/> Cholesterol                 | <input type="checkbox"/> Bloody or black bowel movements | <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Mood swings         |
| <input type="checkbox"/> Heart Attack                | <input type="checkbox"/> Hepatitis                       | <input type="checkbox"/> Muscle or joint pain | <input type="checkbox"/> Suicidal thoughts   |
| <input type="checkbox"/> Chest pain                  | <input type="checkbox"/> Liver                           | <input type="checkbox"/> Back pain            | <input type="checkbox"/> Teeth or gums       |
| <input type="checkbox"/> Blood clots                 | <input type="checkbox"/> Gallbladder                     | <input type="checkbox"/> Seizures             | <input type="checkbox"/> Hair loss or growth |
| <input type="checkbox"/> Varicose veins              | <input type="checkbox"/> Incontinence (urine or feces)   | <input type="checkbox"/> Eyesight             | <input type="checkbox"/> Skin                |
| <input type="checkbox"/> Easy bruising               | <input type="checkbox"/> Breasts                         | <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Frequent falling    |
| <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Endometriosis                   | <input type="checkbox"/> Cataracts            | <input type="checkbox"/> Losing height       |
| <input type="checkbox"/> Indigestion                 | <input type="checkbox"/> Fibroids                        | <input type="checkbox"/> Depression           | <input type="checkbox"/> Broken bones        |
| <input type="checkbox"/> Frequent nausea or vomiting | <input type="checkbox"/> Infertility                     | <input type="checkbox"/> Anxiety              | <input type="checkbox"/> Weight loss or gain |
|  | <input type="checkbox"/> Cancer                          | <input type="checkbox"/> Stress               |  |

Other health problems (describe):

**Section 5. MAJOR ILLNESS AND INJURY HISTORY**

Date	List dates of all operations, hospitalizations, psychological therapy, major injuries, and illnesses (excluding pregnancy).

(Please continue on back, if needed.)

**Section 6. 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

Do you have a uterus?.....  Yes  No  Don't know

Do you have both ovaries?.....  Yes  No  Don't know

Do you have a cervix?.....  Yes  No  Don't know

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

Is there a recent change in how often you have periods?.....  Yes  No

Is there a recent change in how many days you bleed? .....  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 just prior to your period)  Yes  No

Do you examine your breasts? .....  Yes  No If yes, how often? \_\_\_\_\_

Did your mother take DES when she was pregnant with you?  Yes  No  Don't know

Do you douche?.....  Yes  No If yes, how often? \_\_\_\_\_

What is the date and results (if known) of your last test regarding:

Pap smear: \_\_\_\_\_ Any abnormal Pap tests?  Yes  No If yes, when? \_\_\_\_\_

Mammogram: \_\_\_\_\_ Any breast biopsies?  Yes  No If yes, when? \_\_\_\_\_

Thyroid: \_\_\_\_\_ Any abnormal thyroid tests?  Yes  No If yes, when? \_\_\_\_\_

Cholesterol test: \_\_\_\_\_ Colonoscopy: \_\_\_\_\_

Blood sugar test: \_\_\_\_\_ Sigmoidoscopy: \_\_\_\_\_

Fecal occult blood test: \_\_\_\_\_ Bone density test: \_\_\_\_\_

**Section 7. OBSTETRICAL HISTORY**

Please indicate the method of birth control, if any, that you are currently using or have used previously:

	Using Now	Previously Used		Using Now	Previously Used
None	<input type="checkbox"/>	<input type="checkbox"/>	Implanted hormone	<input type="checkbox"/>	<input type="checkbox"/>
Sterilization (tubes tied)	<input type="checkbox"/>	<input type="checkbox"/>	Diaphragm	<input type="checkbox"/>	<input type="checkbox"/>
Male partner had vasectomy	<input type="checkbox"/>	<input type="checkbox"/>	Foam/gel	<input type="checkbox"/>	<input type="checkbox"/>
Birth control pill, ring, or skin patch	<input type="checkbox"/>	<input type="checkbox"/>	Condoms	<input type="checkbox"/>	<input type="checkbox"/>
IUD	<input type="checkbox"/>	<input type="checkbox"/>	Natural family planning/rhythm	<input type="checkbox"/>	<input type="checkbox"/>
Injectable hormone	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

How many times have you been pregnant?

How many children do you have?

How many were adopted?

How old were you when you first child was born?

How old were you when your last child was born?

Please provide the number of your:

Full term births: \_\_\_\_\_ Premature births: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Abortions: \_\_\_\_\_ Living children: \_\_\_\_\_

Any complications during pregnancy, delivery, or postpartum?  Yes  No

If yes, please describe:

**Section 8. SEXUAL HISTORY**

Are you currently sexually active?.....  Yes  No

If yes, are you currently having sex with:  A man (or men)  A woman (or women)  Both men and women

How long have you been with your current sex partner? \_\_\_\_\_

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

If no, do you use condoms (practice safe sex)?.....  Yes  No

In the past, have you had sex with: .....  A man (or men)  A woman (or women)

Have you had any sexually transmitted infections? .....  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 breasts; 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 9. ALLERGY INFORMATION**

Are you allergic to any medications?  Yes  No  Don't know If yes, please indicate which one(s):

Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_

Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_

Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_

Do you have any other allergies?  Yes  No  Don't know If yes, please indicate:

To what? \_\_\_\_\_ Reaction: \_\_\_\_\_

To what? \_\_\_\_\_ Reaction: \_\_\_\_\_

**Section 10. MEDICATION HISTORY**

Are you currently using hormone therapy for menopause?  Yes  No

If no, why not?

If yes, for what reasons?

Please indicate the medications and supplements (such as vitamins, calcium, herbs, soy) you are currently using. Include prescription drugs and those purchased without a prescription. Also include all hormone therapy you have used in the past (examples include contraceptives, thyroid hormones, and hormone therapy for menopause).

Medication/ Supplement	Dose	Frequency	Date Started	Date Stopped	Why Stopped

Have you used any other therapy for menopause (such as acupuncture or yoga)?

Yes  No If yes, please indicate:

Of these, what are you currently using?

Is this therapy helpful?  Yes  No

**Section 11. 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: _____
(including sickle cell trait): _____	Other emotional problems: _____
Blood clots: _____	Alzheimer's disease: _____
Bleeding tendency: _____	Domestic violence victim: _____
Glaucoma: _____	Domestic violence person: _____
Osteoporosis: _____	Sexual abuse victim: _____
Hip fracture: _____	Sexual abuse person: _____
Diabetes: _____	Alcoholism: _____
Breast cancer (indicate age): _____	Drug abuse: _____

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 12. PERSONAL HABITS**

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

**Exercise**

How often do you exercise?     Almost daily     At least 3x/week     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/GI 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 13. 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have difficulty getting to sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have difficulty staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get heart palpitations or a sensation of butterflies in my chest or stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel like my skin is crawling or itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel more tired than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My memory is poor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am more irritable than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel more anxious than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have more depressed moods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am having mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have crying spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I need to urinate more often than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I leak urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have pain or burning when urinating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have bladder infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have uncontrollable loss of stool or gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My vagina is dry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have vaginal itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have an abnormal vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have vaginal infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have pain during intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have pain inside during intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have bleeding after intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I lack desire or interest in sexual activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have difficulty achieving orgasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My opportunity for sexual activity is limited	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My stomach feels like it's bloated or I've gained weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have joint pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Section 14. ABOUT MENOPAUSE AND HORMONE THERAPY**

How do you view menopause?

- Positively.** For example, menopause means no more periods and no more worry about contraception. Menopause marks a new life phase.
- Negatively.** For example, menopause means a loss of fertility and loss of youth.
- Other:

What concerns you about menopause?

(Please continue on back, if needed.)

What are your current views regarding hormone therapy for menopause?

- Positive. Hormone therapy is appropriate for some women.
- Negative. I don't support the use of hormone therapy.

What concerns you most about hormone therapy for menopause?

(Please continue on back, if needed.)

How would you rate your knowledge about menopause?

- Very good
- Fair
- Moderately good
- Little knowledge

How do you get your information about menopause? (Mark all that apply.)

- Books
- Internet
- Magazines
- Friends
- TV
- Healthcare providers

Is there anything else you would like your healthcare provider to know?

(Please continue on back, if needed.)

**Thank you! Please note that the information you have provided will be held in the strictest confidence.**

The North American Menopause Society has provided this form as a service to the healthcare community based on the best understanding of the science related to menopause at the time of publication, but the form should be used with the clear understanding that continued research may result in new knowledge and recommendations. This form is provided only as a diagnostic assist to practitioners making clinical decisions regarding the health of women in their care. Its contents provide guidance and, as such, it cannot substitute for the individual judgment brought to each clinical situation by the caregiver with respect to any additional data that may be required in order to make appropriate clinical decisions. The North American Menopause Society is not responsible nor liable for any advice, diagnosis, course of treatment, or drug or device application based on the healthcare provider's use of this form.