Perpetual HEALTH CENTRE

Your Health. Our Passion

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 calledl 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 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:	Email:	
Address:		
Telephone number (home):	Telephone number (work):	
Telephone number (cell):	Birth date:	Age:
Ethnic/cultural background (please check what applies to you): ☐ Caucasian ☐ Black ☐ Asian ☐ Native American ☐ Biracial ☐ Hispanic/Latina ☐ 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? ☐ Yes ☐ No If yes, why?		For how long?
Who is your primary healthcare provider?		
Address:	Telephone number:	
Do you want to receive periodic helpful health information from The Menopause Center? ☐ Yes, by email ☐ Yes, by mail ☐ No		

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?

Perpetual Health Centre Victoria, British Columbia
375-3066 Shelbourne St, Victoria, BC V8R 6T9, Canada
Phone: +1-250-595-1363 Fax: +1-250-595-2627

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:

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

Perpetual Health Centre Victoria, British Columbia
375-3066 Shelbourne St, Victoria, BC V8R 6T9, Canada
Phone: +1-250-595-1363 Fax: +1-250-595-2627

Section 6. GYNECOLOGIC HISTORY

How would you describe your current menstrual status?

☐ Pre-menopause (before menopause; having regular periods)

☐ Perimenopause/menopause transition (changes in periods, but have not gone 12 months in a row without a period)

☐ Post-menopause (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 our last period? _____

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

How many days does your period last?

Are you 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 you 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: _____

Perpetual Health Centre Victoria, British Columbia
375-3066 Shelbourne St, Victoria, BC V8R 6T9, Canada
Phone: +1-250-595-1363 Fax: +1-250-595-2627

Section 7. OBSTETRICAL HISTORY

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

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

How many times have you been pregnant?

How many children do you have?	How many were adopted?
How old were you when your 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, deliver, or postpartum? ☐ Yes ☐ No

If yes, please describe:

Section 8. MEDICATION

Are you currently using hormone therapy for menopause? ☐ Yes ☐ No

If not, 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

Perpetual Health Centre Victoria, British Columbia
375-3066 Shelbourne St, Victoria, BC V8R 6T9, Canada
Phone: +1-250-595-1363 Fax: +1-250-595-2627

Section 9. FAMILY HISTORY

Please list family member (i.e., 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 (including sickle cell trait):	Depression:
	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 10. 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 diary 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

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? _____

Perpetual Health Centre Victoria, British Columbia
375-3066 Shelbourne St, Victoria, BC V8R 6T9, Canada
Phone: +1-250-595-1363 Fax: +1-250-595-2627

Section 10. PERSONAL HABITS (CONTINUED)

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 anyone?	☐ Yes	☐ No	
Within the last year, has anyone every 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 11. HOT FLASHES

Please mark next to one number to the right of each phrase to describe how much **DURING THE PAST WEEK** hot flashes have **INTERFERED** with each aspect of your life. Higher numbers indicate more interference with your life. If you are not experiencing hot flashes or if hot flashes do not interfere with these aspects of your life, please mark zero to the right of each question.

	Do not interfere										**Completely interfere**
1. Work (work outside the home and housework)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Social activities (time spent with family, friends, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Leisure activities (time spent relaxing, doing hobbies, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Sleep	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Mood	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Concentration	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. Relations with others	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. Sexuality	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. Enjoyment of life	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. Overall quality of life	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Section 12. SEXUAL HEALTH

How often would you like to have sex?	☐ Never/Not interested	☐ Monthly	☐ Weekly	☐ Every 2 to 3 days	☐ Every day	☐ Multiple times a day
How often do you actually have sex?	☐ Never/Not interested	☐ Monthly	☐ Weekly	☐ Every 2 to 3 days	☐ Every day	☐ Multiple times a day
How often do you experience pain / discomfort during intercourse?	☐ Always	☐ Very frequently	☐ Occasionally	☐ Rarely	☐ Very Rarely	☐ Never
To what degree does this discomfort affect your sex life?	☐ Not at all	☐ Very little	☐ Somewhat	☐ Quite a bit	☐ To a great extent	☐ No longer any interest in sex

If you experience pain / discomfort during intercourse:
How long ago did the pain start? _____
Please describe the pain: ☐ Pain with penetration ☐ Pain inside ☐ Feels dry

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	

1. How strong is your sex drive?	☐ Extremely strong	☐ Very strong	☐ Somewhat strong	☐ Somewhat weak	☐ Very weak	☐ No sex drive
2. How are you sexually aroused?	☐ Extremely easily	☐ Very easily	☐ Somewhat easily	☐ Somewhat difficult	☐ Very difficult	☐ Never aroused
3. How easily does you vagina become moist or wet?	☐ Extremely easily	☐ Very easily	☐ Somewhat easily	☐ Somewhat difficult	☐ Very difficult	☐ Never
If you have had any sexual activity in the past week, please also answer the following two questions. If not, leave questions 4 and 5 blank. ☐ No sexual activity in the past week						
4. How easily can you reach an orgasm?	☐ Extremely easily	☐ Very easily	☐ Somewhat easily	☐ Somewhat difficult	☐ Very difficult	☐ Never reach orgasm
5. Are your orgasms satisfying?	☐ Extremely satisfying	☐ Very satisfying	☐ Somewhat satisfying	☐ Somewhat unsatisfying	☐ Very unsatisfying	☐ Can't reach orgasm

Section 13. MOOD

Over the **last 2 weeks**, how often have you been bothered by any of the following problems:	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself- or that you are failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?	**Not at all difficult** ☐	**Somewhat difficult** ☐	**Very difficult** ☐	**Extremely difficult** ☐

Section 14. ANXIETY

Over the **last 2 weeks**, how often have you been bothered by the following problems:	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it's hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7.Feeling afraid as if something awful might happen	☐	☐	☐	☐
If you checked off **any** problems, how **difficult** have these made it for you to do your work, take care of things at home, or get along with other people?	**Not at all difficult** ☐	**Somewhat difficult** ☐	**Very difficult** ☐	**Extremely difficult** ☐

Section 15. 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 get heart palpitations or a sensation or butterflies in my chest or stomach	☐	☐	☐	☐
I feel like my skin is crawling or itching	☐	☐	☐	☐
My memory is poor	☐	☐	☐	☐
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	☐	☐	☐	☐
My stomach feels like it's bloated or I've gained weight	☐	☐	☐	☐
I have breast tenderness	☐	☐	☐	☐
I have joint pains	☐	☐	☐	☐
I have crying spells	☐	☐	☐	☐

Section 16. 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 stage.
☐ **Negatively.** For example, menopause means a loss of fertility and loss of youth.
☐ **Other:**

What concerns you about menopause?

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?

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?

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

Perpetual Health Centre Victoria, British Columbia
375-3066 Shelbourne St, Victoria, BC V8R 6T9, Canada
Phone: +1-250-595-1363 Fax: +1-250-595-2627