

Menopause Health Questionnaire

Please complete before your visit

Your answers help your clinician understand your menopause experience and build a care plan that fits your health and goals. Skip any question you would rather discuss in person. Your information is kept confidential.

01 ABOUT YOU

Full name	Date of birth	Today's date
Address	Phone	Email
Primary care clinician	Referred by	
Occupation	Preferred name	

02 REASON FOR YOUR VISIT

What are your main concerns, questions, or goals for today's visit?

03 PERIODS AND MENOPAUSE STATUS

Which best describes you now?

- | | |
|--|--|
| ☐ Regular periods, no recent change | ☐ Periods changing (irregular, skipped, heavier, or lighter) |
| ☐ No period for 12 months or more | ☐ Not sure (e.g., hysterectomy, hormonal IUD, or birth control) |

Age at first period / age at last period (if stopped)

First: _____ Last: _____

If periods have stopped, why?

☐ Natural ☐ Surgery ☐ Chemo / radiation ☐ Other

Do you still have your uterus? Your ovaries?

Uterus: ☐ Yes ☐ No Ovaries: ☐ Both ☐ One ☐ None

If still having periods: days between periods: _____ days

Total days of bleeding each month: _____ days

Any of these bleeding changes? (check all that apply)

- | | |
|--|--|
| ☐ Very heavy bleeding (soaking a pad or tampon every 1–2 hours, or large clots) | ☐ Bleeding or spotting between periods |
| ☐ Bleeding after sex | ☐ Any bleeding after 12 months without a period |
| ☐ None of these | |

Current birth control (still needed until menopause is confirmed)

- | | | | |
|---|---|---|---------------------------------------|
| ☐ None / not needed | ☐ Pill, patch, or ring | ☐ Hormonal IUD | ☐ Copper IUD |
| ☐ Implant or injection | ☐ Condoms | ☐ Tubal ligation / partner vasectomy | ☐ Other: _____ |

04 SYMPTOMS

How much have you been bothered by each of the following in the past 4 weeks?

Symptom	Not at all	A little	Moderately	Severely
HOT FLASHES AND SWEATS				
Hot flashes during the day (about ____ per day)	☐	☐	☐	☐
Night sweats (about ____ per night)	☐	☐	☐	☐
SLEEP				
Trouble falling asleep	☐	☐	☐	☐
Waking during the night / early morning	☐	☐	☐	☐
Loud snoring or pauses in breathing	☐	☐	☐	☐
Daytime tiredness or low energy	☐	☐	☐	☐
MOOD AND THINKING				
Irritability	☐	☐	☐	☐
Anxiety or feeling on edge	☐	☐	☐	☐
Low or depressed mood	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐
Trouble concentrating or "brain fog"	☐	☐	☐	☐
Forgetfulness	☐	☐	☐	☐
BODY				
Heart racing or palpitations	☐	☐	☐	☐
Joint or muscle aches	☐	☐	☐	☐
Headaches or migraines	☐	☐	☐	☐
Weight gain, especially around the waist	☐	☐	☐	☐
Hair thinning or dry skin	☐	☐	☐	☐
VAGINAL AND URINARY				
Vaginal dryness, itching, or irritation	☐	☐	☐	☐
Pain or discomfort with sex	☐	☐	☐	☐
Frequent or urgent need to urinate	☐	☐	☐	☐
Leaking urine	☐	☐	☐	☐
Repeated bladder infections	☐	☐	☐	☐
SEXUAL HEALTH				
Low interest in sex	☐	☐	☐	☐
Difficulty with arousal or orgasm	☐	☐	☐	☐

05 EMOTIONAL WELL-BEING

Over the past 2 weeks, how often have you been bothered by the following?

In the past 2 weeks	Not at all	Several days	Over half the days	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Thoughts that you would be better off dead, or of hurting yourself	☐	☐	☐	☐

If you are having thoughts of harming yourself, please tell a staff member today, or call or text 988 (Suicide & Crisis Lifeline) at any time.

06 PREGNANCY HISTORY

Number of pregnancies / births

Pregnancies: _____ Births: _____

Did you have any of these during pregnancy? (these can affect future heart health)

- | | | |
|--|--|--|
| ☐ High blood pressure or preeclampsia | ☐ Gestational diabetes | ☐ Preterm birth (before 37 weeks) |
| ☐ Baby small for gestational age | ☐ Postpartum depression | ☐ None / not applicable |

07 MEDICAL HISTORY

Please check any condition you have now or have had in the past.

Heart and blood vessels

- | | | |
|--|---|--|
| ☐ High blood pressure | ☐ High cholesterol | ☐ Heart attack or coronary artery disease |
| ☐ Stroke or mini-stroke (TIA) | ☐ Blood clot in leg or lung (DVT / PE) | ☐ Inherited clotting disorder |
| ☐ Irregular heartbeat (e.g., atrial fibrillation) | ☐ Migraine with aura | ☐ Varicose veins |

Cancer and genetics

- | | | |
|--|---|--|
| ☐ Breast cancer | ☐ Uterine (endometrial) cancer | ☐ Ovarian cancer |
| ☐ Colon cancer | ☐ Other cancer: _____ | ☐ BRCA, Lynch, or other gene mutation |
| ☐ Breast biopsy with atypia | ☐ Dense breasts on mammogram | ☐ Abnormal Pap / HPV |

Bone health

- | | | |
|---|---|--|
| ☐ Osteopenia or osteoporosis | ☐ Broken bone after age 45 from a minor fall | ☐ Lost 1.5 inches or more in height |
| ☐ Fall in the past year | ☐ Long-term steroid use (e.g., prednisone) | ☐ Eating disorder (past or present) |

Other conditions

- | | | |
|---|--|---|
| ☐ Diabetes or prediabetes | ☐ Thyroid disease | ☐ Liver disease |
| ☐ Gallbladder disease | ☐ Kidney disease | ☐ Sleep apnea |
| ☐ Autoimmune disease (e.g., lupus, RA) | ☐ Endometriosis or fibroids | ☐ Polycystic ovary syndrome (PCOS) |
| ☐ Depression or anxiety | ☐ Menopause before age 45 | ☐ Other: _____ |

Surgeries and hospitalizations

Year	Surgery, hospitalization, or major illness

08 MEDICATIONS AND ALLERGIES

Are you using hormone therapy for menopause now?

☐ Yes ☐ No

Have you used hormone therapy in the past?

☐ Yes ☐ No If stopped, why? _____

Have you tried other treatments for symptoms (e.g., nonhormonal medicines, CBT, acupuncture, herbal products)?

☐ Yes ☐ No What helped? _____

List all current prescriptions, over-the-counter medicines, vaginal products, vitamins, and supplements.

Medication or supplement	Dose	How often	Reason

Do you have any medication allergies?

☐ No ☐ Yes If yes, list below

Medication or other allergen	Reaction

09 FAMILY HISTORY

Include parents, siblings, children, grandparents, aunts, and uncles.

Condition	Family member(s)	Age at diagnosis
Breast cancer		
Ovarian or fallopian tube cancer		
Uterine (endometrial) cancer		
Colon cancer		
Known gene mutation (BRCA, Lynch, other)		
Heart disease (men before 55, women before 65)		
Stroke		
Blood clots or clotting disorder		

Condition	Family member(s)	Age at diagnosis
Osteoporosis or hip fracture		
Dementia / Alzheimer's disease		
Diabetes		
Early menopause (before 45)		

10 HEALTH SCREENING

Approximate date of your most recent test, if known.

Test	Date (month / year)	Result
Cervical screening (Pap and/or HPV)		☐ Normal ☐ Abnormal ☐ Not sure
Mammogram		☐ Normal ☐ Abnormal ☐ Not sure
Bone density (DXA) scan		☐ Normal ☐ Abnormal ☐ Not sure
Colon screening (colonoscopy or stool test)		☐ Normal ☐ Abnormal ☐ Not sure
Cholesterol		☐ Normal ☐ Abnormal ☐ Not sure
Blood sugar or A1c		☐ Normal ☐ Abnormal ☐ Not sure
Thyroid test		☐ Normal ☐ Abnormal ☐ Not sure

11 LIFESTYLE

Height	Weight	Tallest adult height	Weight change past year
How would you rate your overall health?			
		☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor	
Minutes of moderate exercise per week (e.g., brisk walking)		_____ minutes / week	
Days per week of strength or resistance training		_____ days / week	
Servings per day of calcium-rich foods (dairy, fortified foods)		_____ servings / day	
Do you take calcium or vitamin D supplements?		☐ Calcium ☐ Vitamin D ☐ Neither	
Tobacco or nicotine (cigarettes, vaping, other)		☐ Never ☐ Former ☐ Current Amount: _____	
Alcoholic drinks per week		_____ drinks / week	
In the past year, have you had 4 or more drinks on one occasion?		☐ Yes ☐ No	
Cannabis use (any form)		☐ Never ☐ Occasionally ☐ Regularly	
Caffeinated drinks per day		_____ / day	
Are you a caregiver for children, parents, or others?		☐ Yes ☐ No	

12 SEXUAL HEALTH AND SAFETY

Are you currently sexually active?	☐ Yes ☐ No
Have you had a new sexual partner in the past year?	☐ Yes ☐ No
Would you like to discuss sexual health or your sex life today?	☐ Yes ☐ No
Do you feel safe at home and in your relationships?	☐ Yes ☐ No

In the past year, has anyone hurt, threatened, or forced you into sexual activity?

☐ Yes ☐ No

13 YOUR VIEWS AND PREFERENCES

How do you feel about menopause?

☐ Positive ☐ Neutral ☐ Negative ☐ Mixed

How do you feel about hormone therapy?

☐ Open to it ☐ Unsure ☐ Prefer to avoid

How would you rate your knowledge about menopause?

☐ Good ☐ Fair ☐ Limited

Which options would you like to discuss? (check all that apply)

☐ Hormone therapy

☐ Nonhormonal prescription options

☐ Vaginal moisturizers or low-dose vaginal therapy

☐ Sleep, nutrition, and exercise

☐ Cognitive behavioral therapy (CBT)

☐ Bone and heart health

☐ Sexual health

☐ Weight management

☐ Not sure yet

Where do you usually get information about menopause?

☐ Healthcare clinicians

☐ Medical society websites

☐ Other websites

☐ Social media

☐ Podcasts or videos

☐ Books or news

☐ Friends or family

☐ Other

What concerns you most about menopause or its treatment? Any major stressors or life changes? Anything else we should know?

Thank you. Please submit this form and a current list of your medications by email prior to your appointment. Send to info@drcherylkinney.com

FOR CLINIC USE

BP _____ BMI _____ Waist _____ Reviewed by _____ Date _____