NAMS
THE NORTH AMERICAN MENOPAUSE SOCIETY

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: Email:

Address: City, State, Zip Code

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:

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:

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

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	❑	❑	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 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:

Heart attack (indicate age):

Stroke (indicate age):

Blood problems (including sickle cell trait):

Blood clots:

Bleeding tendency:

Glaucoma:

Osteoporosis:

Hip fracture:

Diabetes:

Breast cancer (indicate age):

Colorectal cancer:

Ovarian cancer:

Other cancer:

Depression:

Other emotional problems:

Alzheimer's disease:

Domestic violence victim:

Domestic violence person:

Sexual abuse victim:

Sexual abuse person:

Alcoholism:

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	❑	❑	❑	❑
I have night sweats	❑	❑	❑	❑
I have difficulty getting to sleep	❑	❑	❑	❑
I have difficulty staying asleep	❑	❑	❑	❑
I get heart palpitations or a sensation of butterflies 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	❑	❑	❑	❑

Section 14. RISK ASSESSMENT (optional)

The following questions will help determine your risk for disease later on in life.
Please check all that apply to you.

Osteoporosis risk

- ❑ Bone density test shows low bone mass
- ❑ Bone density test shows osteoporosis
- ❑ Family history of osteoporosis
- ❑ Small, thin frame
- ❑ Caucasian or Asian
- ❑ Missed menstrual period for 6 months or more (not including when pregnant or breastfeeding)
- ❑ Menopause at or before age 40
- ❑ Taking thyroid, antiseizure, anticoagulant, or cortisone medication
- ❑ Diet low in milk and dairy products
- ❑ Do not take calcium supplements
- ❑ More than 7 alcoholic drinks each week
- ❑ Prolonged bed rest
- ❑ Exercise less than 3 times a week
- ❑ Cannot rise from chair without using arms
- ❑ Cannot rise from floor without difficulty
- ❑ Frequent falls
- ❑ Previous episodes of severe dieting, bulimia, or anorexia
- ❑ Hemophilia
- ❑ Type I diabetes
- ❑ Chronic liver or kidney disease
- ❑ Crohn's disease
- ❑ Rheumatoid arthritis
- ❑ Current smoker
- ❑ Spend little or no time in sunlight and don't take vitamin D
- ❑ Loss of height greater than 1.5 inches
- ❑ Previous fracture
- ❑ More than one previous fracture
- ❑ Scoliosis
- ❑ Back pain
- ❑ Gum disease or tooth loss

Cardiovascular risk

- ❑ Previous heart attack
- ❑ Previous stroke
- ❑ Previous or current chest pain (angina)
- ❑ Previous or current heart rhythm problem (arrhythmia)
- ❑ Diabetes
- ❑ High blood pressure
- ❑ High total cholesterol
- ❑ Low HDL (good cholesterol)
- ❑ High triglycerides
- ❑ Current smoker
- ❑ Over 65 years old
- ❑ Black skin color
- ❑ My shape is like an apple (waist bigger than hips)
- ❑ Exercise less than 3 times a week
- ❑ More than 30% over ideal weight (eg, should be 120 pounds, but now weigh 160; should be 150 pounds, but now weigh 200)
- ❑ Have not cut down on fat in my diet
- ❑ Family history of heart disease

Cancer risk

A. Cervical cancer risk

- ❑ Smoking
- ❑ Genital warts (HPV)
- ❑ Abnormal Pap test
- ❑ Sexual intercourse at an early age
- ❑ Multiple sexual partners
- ❑ Sexual partners who have had multiple sexual partners
- ❑ HIV
- ❑ Have unsafe sex (without a condom)

B. Uterine cancer risk

(If you no longer have a uterus, skip to C.)

- ❑ More than 30% over ideal weight (eg, should be 120 pounds, but now weigh 160; should be 150 pounds, but now weigh 200)
- ❑ Unexplained uterine bleeding
- ❑ Prolonged time spans without menstrual periods (except when pregnant)
- ❑ Have not given birth
- ❑ Began menstrual periods before age 12
- ❑ Reached menopause after age 53
- ❑ Diabetes
- ❑ Gallbladder disease
- ❑ Use of tamoxifen
- ❑ Use of estrogen therapy for menopause without adding a progestogen

C. Breast cancer risk

- ❑ Mother or sister diagnosed with breast cancer before menopause
- ❑ Previous breast, uterine, or ovarian cancer
- ❑ Positive *BRCA1* (gene mutation)
- ❑ Reached menopause after age 55
- ❑ Began menstrual periods before age 12
- ❑ Had first child after age 30
- ❑ No children
- ❑ More than 30% over ideal weight (eg, should be 120 pounds, but now weigh 160; should be 150 pounds, but now weigh 200)
- ❑ Drinking more than 7 alcoholic drinks each week
- ❑ Lack of exercise
- ❑ Diet low in vegetables and fruits
- ❑ Have used estrogen therapy more than 5 years

(continued)

Section 14. RISK ASSESSMENT (continued)

D. Ovarian cancer risk

- ❑ No children
- ❑ Previous breast or uterine cancer
- ❑ Family history of ovarian, breast, or uterine cancer
- ❑ Positive *BRCA1* and *BRCA2*

E. Colorectal cancer risk

- ❑ History of colorectal cancer or adenomatous polyps
- ❑ Family history of colorectal cancer or adenomatou polyps
- ❑ Inflammatory bowel disease
- ❑ Diet low in vegetables, fruits, and fiber
- ❑ Smoking

F. Lung cancer risk

- ❑ History of lung cancer
- ❑ Family history of lung cancer
- ❑ Current smoker
- ❑ Previous smoker
- ❑ Smoker in home
- ❑ Work around asbestos, smokers, or talc
- ❑ Work around cancer-causing chemicals (gasoline, diesel exhaust, arsenic, uranium, vinyl chloride, nickel chromates, coal products, mustard gas, chloromethyl ethers)
- ❑ Exposure to radon gas
- ❑ Smoke marijuana
- ❑ History of tuberculosis

G. Skin cancer risk

- ❑ Light skin color
- ❑ Previous skin cancer
- ❑ Family history of skin cancer
- ❑ Severe sunburn(s) when a child
- ❑ Numerous moles and freckles
- ❑ Sunbathe regularly or for longer than 1-hour sessions
- ❑ Visit tanning salons

Section 15. 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.