The Menopause Center

Menopause Health Questionnaire

Menopause is a normal event in a woman's life and is marked by the end of menstrual peiods. Usually during the 40s, a gradual process leading to menopause begins. This is call 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:	

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?

Baylor College of Medicine – Obstetrics & Gynecology
Texas Children's Pavilion for Women, 6651 Main Street, Suite F320, Houston, Texas 77030
Phone: 832.826.5281 Fax: 832.825.9367

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	☐ 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)

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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: _____

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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. 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 medication?	☐ Yes	☐ No	☐ Don't know
If yes, please indicate which ones:			
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 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

Section 11: 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 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 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?

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?

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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 or 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 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. 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?

(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 of confidence.

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