The Menopause Center

Menopause Health Follow-up Questionnaire

This questionnaire is intended to help you inform your healthcare provider about your current menopause experience and your general health. 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

Name:	Date:
Birthdate:	Email:
Address:	
Do you want to receive periodic helpful health information from The Menopause Center? ☐ Yes, by email ☐ Yes, by mail ☐ No	

Section 2. 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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Phone: 832.826.5281 Fax: 832.825.9367

Section 3. SEXUAL HEALTH

1. How often would you like to have sex?	☐ Never/Not interested	☐ Monthly	☐ Weekly	☐ Every 2 to 3 days	☐ Every day	☐ Multiple times a day
2. How often do you actually have sex?	☐ Never/Not interested	☐ Monthly	☐ Weekly	☐ Every 2 to 3 days	☐ Every day	☐ Multiple times a day
3. How often do you experience pain / discomfort during intercourse?	☐ Always	☐ Very frequently	☐ Occasionally	☐ Rarely	☐ Very Rarely	☐ Never
4. 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

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 4. 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 a 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** ☐

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Section 5. 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 6. 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	☐	☐	☐	☐
I have headaches	☐	☐	☐	☐

What other symptoms are you experiencing?

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

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