MENOPAUSE QUESTIONNAIRE

Female Last Name: _____ First Name: _____
Name on OHIP card: _____
Health Card Number: _____ Letters: _____Date of Birth: _____ Age: _____
Home Address: _____City: _____ Postal Code: _____
Home Phone: _____ Work Phone: _____
Are you currently working?:_____ Profession _____
Name of Referring M.D.: _____Phone No. of Referring M.D.: _____

Age at time on menopause_____ ☐ Not yet in menopause
(i.e when you had your final menstrual period, or noticed symptoms like hot flashes)
If in menopause, was it: ☐ Natural ☐ Surgical (hysterectomy) ☐ Other _____

Please rate the severity of the following menopausal symptoms you have now:
Mild – symptoms do not interfere with usual activities: Moderate: - symptoms interfere somewhat"
Severe: - symptoms so severe, that usual activities cannot be performed

	Mild	Moderate	Severe	Comments
Hot flashes				
Night sweats				
Vaginal dryness/itching				
Bladder infections				
Urinary leakage				
Palpitations				
Mood swings/irritable				
Anxiety or depression				
Decreased sexual desire				
Tired				
Difficulty sleeping				
Skin problems				
Difficulty concentrating /memory loss				
Joint aches and pains				
Other:				
Other:				

Reproductive health
Age at first period _____ Menstrual history: do you, or did you have problems with your period? NO ☐ YES ☐
☐ Very heavy ☐ Irregular in timing / unpredictable ☐ Very painful ☐ Other
Number of pregnancies_____ Number of births _____ Number of children _____
History of infertility? ☐ Yes ☐ No If yes: IVF ovulation medications _____
Any surgery on reproductive tract? ☐ Tubes tied ☐ Laparoscopy or hysteroscopy ☐ Removal of polyp
☐ Hysterectomy ☐ Other _____
Are you currently sexually active: ☐ Yes ☐ No
If yes, are you using contraception? Yes (type) _____ ☐ not needed
If yes, do you have pain or discomfort with intercourse? ☐ Yes ☐ No

Vaginal health
Do you have ☐ Vaginal dryness ☐ Itching ☐ Burning ☐ Pain ☐ Discharge ☐ Other
Do you douche☐ Yes ☐ No Do you use vaginal creams? ☐ Yes ☐ No
History of sexually transmitted infection (such as warts, herpes, Chlamydia) _____
Sexual orientation ☐ Heterosexual ☐ Homosexual ☐ Bisexual
Do you get Pap smears every year or two? ☐ Yes ☐ No ☐ Unsure
Have you ever had an abnormal Pap smear requiring colposcopy or treatment? ☐ Yes ☐ No
If yes, when and what type? _____

General Health

Do you have high blood pressure: ☐ Yes ☐ No ☐ Unsure

Do you have diabetes? ☐ Yes ☐ No ☐ Unsure

Do you have high cholesterol? ☐ Yes ☐ No ☐ Unsure

Do you have any other medical problems, illnesses, or needed to see a specialist? If yes please explain:

_____

Have you ever had surgery or an operation? If yes please explain

_____

Do you take any medications, vitamins, or herbal remedies on a daily basis?

_____

Do you have any allergies? Please list if any _____

Do you smoke? ☐ Yes ☐ No _____ pack(s) per day _____ For how many years?

_____

How many alcohol drinks do you have per day? ☐ 1 or less ☐ 2 ☐ $\geq$ 3

How many caffeine drinks do you have per day? ☐ 1 or less ☐ 2 ☐ $\geq$ 3

Do you use drugs? ☐ Yes ☐ No

Have you been hit, slapped, kicked or physically hurt by someone? ☐ Yes ☐ No

If yes, within the last year? ☐ Yes ☐ No

Do you have any of the following?

☐ Thyroid disease ☐ Abdominal pain ☐ Joint swelling ☐ Eye problems ☐ Liver disease ☐ Skin problems

☐ Hearing problems ☐ Vomiting, diarrhea ☐ Infections (HIV, Hepatitisbmo.ca

☐ Dizziness ☐ Constipation

☐ Bladder infections ☐ Coughing, wheezing ☐ Rectal bleeding ☐ Kidney stones ☐ Chest pain, short breath

☐ Easy bruising, bleeding ☐ Difficulty walking

How would you rate you health? ☐ Good ☐ Fair ☐ Poor

Bone Health

Do you have low bone density, osteopenia, and osteoporosis? ☐ Yes ☐ No ☐ Unsure

Have you ever had a fracture (such as spine, hip, wrist ?) ☐ Yes ☐ No ☐ Unsure

If yes, how old were you? _____

Have you taken any of the following medications for 3 months or more?

☐ Steroids (like Prednisone) ☐ Anti seizure medication ☐ Heparin (blood thinner)

Do you have high thyroid or high parathyroid hormone levels? ☐ Yes ☐ No ☐ Unsure

How many servings of milk, cheese, and yogurt do you have per day? ☐ 1 or less ☐ 2 ☐ $\geq$ 3

Do you take supplements of calcium? ☐ Yes ☐ No

Do you take supplements of Vitamin D? ☐ Yes ☐ No If yes, how much per day? _____

How many times do you exercise per week? ☐ Hardly ever ☐ 1-2 ☐ 3-4 ☐ Almost daily

Breast Health

Have you ever had a breast lump, cyst or biopsy? ☐ Yes ☐ No ☐ Unsure

How old were you at the birth of your first child? _____ ☐ Not applicable

Did you breastfeed? ☐ Yes ☐ No

Emotional Health

Have you ever been diagnosed with depression, anxiety or other mental health problem? ☐ Yes ☐ No

If yes, do you see a psychiatrist or therapist? ☐ Yes ☐ No.

If yes, have you been hospitalized for this problem? ☐ Yes ☐ No

If yes, is it or was it related to times of hormonal changes? ☐ Yes ☐ No

☐ Premenstrual syndrome (PMS) ☐ Pregnant / Post-partum ☐ Menopause

Family History

Condition	Family Member(s)	Age	Yes	No	Unsure
Heart disease					
Stroke					
Breast cancer					
Caner of the cervix, uterus or ovary					
Cancer of the rectum or bowel					
Hip fracture or osteoporosis					