

For office use:

Chart # _____



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Menopause Questionnaire

Name: _____ **DOB:** _____

What is your menopause status?

- Pre-menopausal - still having monthly cycles
- Peri-menopausal- cycles have become irregular or infrequent.
- Post-menopausal- have gone 12 complete months without a cycle
- I have no idea (I currently have an IUD or taking another form of birth control, have had a hysterectomy, or have had an endometrial ablation).

When was your last menstrual period? _____

If still cycling, how often are you having periods? _____

If in menopause, how old were you at the time of your last period? _____

If in menopause, have you experienced Post Menopausal Bleeding? Yes or No

If you circled yes, please state when you last had PMB: _____

- Have you had a hysterectomy? Yes / No
- If you circled Yes, please explain why you had it done:

- If you circled Yes, who was your surgeon? _____
 - Year of surgery? _____
 - Do you still have your ovaries? Yes / No / Unsure

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Symptoms: Please list your top 3 concerns you would like addressed at visit

- 1)
- 2)
- 3)

****Please Note**:** If you have more than three concerns you would like to discuss, it may require a second visit

Things you have tried for your symptoms:

Please include the dosage of each medication you are taking for your menopause symptoms:

1. Over the counter supplements for menopause symptoms:

2. Prescribed Medications for menopause symptoms:

Are you currently or have you ever been on hormone therapy (including pellets)? Yes / No

If you circled yes, who prescribed your hormone therapy? _____

When did you start hormone therapy? _____

How long have you been on hormone therapy? _____

Which hormones have you tried? (circle all that apply)

Systemic Estrogen

Vaginal Estrogen

Progesterone

Testosterone

If you circled no, are you interested in hormone therapy ? Yes / No / Unsure

**** Please note: Our office is not in practice of prescribing or inserting hormone pellets****

Smoking Status: (Please check)

- Never smoker
- Current Smoker
 - How much do you smoke per day? _____
- Former smoker.
 - How many years did you smoke? _____
 - When did you quit? _____

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Please circle if you have been diagnosed with any of the following:

High Blood Pressure

Thyroid Disorder

Liver Disease

Blood Clots

Mood Disorder

Osteoporosis/ Osteopenia

Breast Cancer

BRCA gene mutation

Heart Disease

Depression/Anxiety

Stroke

Migraines

High Cholesterol

Clotting disorder

Dementia / Alzheimer's

Diabetes

Other cancer: _____

Menopause Symptoms: Please check all that apply and HIGHLIGHT or UNDERLINE your TOP 3 most bothersome symptoms

- | | |
|--|---|
| <input type="checkbox"/> Hot flashes / Night sweats | <input type="checkbox"/> Body odor |
| <input type="checkbox"/> Mood changes (irritability, anxiety, depression, etc) | <input type="checkbox"/> Heavy or prolonged periods |
| <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Weight gain or weight distribution changes |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Frozen Shoulder |
| <input type="checkbox"/> Vaginal dryness, itching, or irritation | <input type="checkbox"/> Muscle loss (sarcopenia) |
| <input type="checkbox"/> Painful sex | <input type="checkbox"/> Ringing in the ears (tinnitus) |
| <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Itchy ears |
| <input type="checkbox"/> Tender breasts | <input type="checkbox"/> Eye twitching |
| <input type="checkbox"/> Digestive issues (bloating, constipation, diarrhea) | <input type="checkbox"/> Autoimmune flare ups |
| <input type="checkbox"/> Migraines | |
| <input type="checkbox"/> Brain fog | |
| <input type="checkbox"/> Memory problems | |
| <input type="checkbox"/> Joint pain | |
| <input type="checkbox"/> Muscle aches | |
| <input type="checkbox"/> Osteoporosis or Osteopenia | |
| <input type="checkbox"/> Heart palpitations | |
| <input type="checkbox"/> Dry, itchy skin | |
| <input type="checkbox"/> Hair loss | |
| <input type="checkbox"/> Burning mouth syndrome | |
| <input type="checkbox"/> Urinary changes (frequency, urgency) | |