

Perimenopause/Menopause Symptom Questionnaire

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Contact details: \_\_\_\_\_

Date: \_\_\_\_\_ Review Number/follow up interval: \_\_\_\_\_

Currently on HRT: Yes/No

Details of treatment:

Please mark the box to show how much you are troubled by the following symptoms and add any others:

Symptoms	Not at all	A little	Quite a bit	A lot
1. Heart beating strongly or quickly				
2. Feeling tense or nervous				
3. Difficulty in sleeping				
4. Excitable				
5. Memory problems				
6. Panic attacks or anxiety				
7. Difficulty in concentration				
8. Feeling tired or lack of energy				
9. Loss of interest in most things				
10. Feeling unhappy or depressed				
11. Crying spells				
12. Irritability				
13. Feeling dizzy or faint				
14. Pressure or tightness in the head or body				
15. Tinnitus				
16. Headaches				
17. Muscle or joint pains				
18. Pins and needles in any part of the body				
19. Breathing problems				
20. Hot flushes				
21. Sweating at night				
22. Loss of interest in sex/loss of libido				
23. Vaginal dryness				
24. Urinary symptoms				
25. Changes in hair or skin				

Perimenopause/Menopause Symptom Questionnaire

Health Questionnaire

Gynae History

Date of last menstrual period	
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L'Aumone Surgery  
L'Aumone  
Castel  
GY5 7RU  
01481 256517

St Sampsons Medical Centre  
Grandes Maisons Road  
St Sampsons  
GY2 4JS  
01481 245915

Town Surgery  
1 Le Truchot  
St Peter Port  
GY1 1WD  
01481 724747

Accounts Department: [accounts@health.gg](mailto:accounts@health.gg)/01481 243203 General Enquiries: [enquiries@health.gg](mailto:enquiries@health.gg)

Duration of bleed, cycle length (from first day of bleed)	
Any bleeding in between periods or after sex?	
History of gynae surgery?	
Have you had a hysterectomy?	
Are you on contraception?	
Current HRT?	
Mirena Coil?	
Last smear test date	

Lifestyle and Past Medical History

Do you smoke? Details please:	
How much alcohol do you drink per week (units)?	
Details of your diet e.g., vegetarian, vegan, exclusions	
Any Migraine, blood clots (DVT/PE), clotting disorder, High blood pressure, any cardiac problems or history of stroke?	
Any personal history of breast cancer or other cancer?	
Any family history of cancer, stroke, or blood clots (first degree relative, please state age and relationship)?	
Do you use any complementary medicines e.g., St John's wort?	
Do you take any vitamins or supplements?	
Medication Allergies?	

Height	
Weight	
BP	

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