IslandHealth
Committed to Patient Care Since 1894

CHKS

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 Questionnaire

Name: DOB:

Health questionnaire

Gynae History

Date of last menstrual period	
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?	
Are you currently taking HRT?	
Do you have a Mirena Coil? If yes, when was it fitted?	
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 eg vegetarian, vegan, exclusions	
Any migraine, blood clots (DVT/PE), clotting disorder, high blood pressure, heart problems or history of stroke?	
Any history of liver problems?	
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 eg St. Johns Wort?	
Do you take any vitamins or supplements?	
Medication Allergies?	

Height	
Weight	
BP	