

JANDRUGS.CA

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MENOPAUSE HEALTH QUESTIONNAIRE

Menopause is a normal event in a woman's life and is marked by the end of menstrual periods. Usually during the 40s, a gradual process leading to menopause begins. This is called the menopause transition or perimenopause. Changes in the pattern of menstrual periods are very common during this stage. Sometimes a woman can have other symptoms too and these symptoms may extend beyond menopause. Even if a woman has no symptoms, it's important for her to understand the effects of menopause on her health.

This questionnaire is intended to help you to inform your healthcare provider about your menopause experience and your general health. Working together, you can develop a plan to support your health, not only now, but also in years to come. 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

| | | |
|--|-------------------------|------|
| Date: | | |
| Name: | | |
| Address: | | |
| Telephone Number (home): | Telephone Number (work) | |
| Telephone Number (cell): | Birth date: | Age: |
| Ethnic cultural background (please check what applies to you) Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Biracial <input type="checkbox"/> Hispanic/Latina <input type="checkbox"/> Other (please specify) <input type="checkbox"/> | | |
| Marital status (circle) Single Married Divorced Widowed Committed Relationship | | |
| Name of primary support person: | | |
| Relationship: | | |
| Primary support person telephone number: | | |
| Employment status (circle) Unemployed Employed Retired Disabled | | |
| If employed, occupation: | | |
| Who is your primary healthcare advisor: | | |
| Address: | Telephone Number: | |

Section 2: HEIGHT & WEIGHT INFORMATION

| | |
|--|------------------------|
| What is your height? | |
| What is your maximum remembered height? | How old were you then? |
| What is your weight? | |
| What is your maximum remembered weight? | How old were you then? |
| What is your lowest remembered weight as an adult? | How old were you then? |

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Section 3: MEDICAL HISTORY

Please check if you have problems with:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Colitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Constipation | <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Bloody or Black Bowel Movements | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Muscle or joint pain | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Liver | <input type="checkbox"/> Back pain | <input type="checkbox"/> Teeth or gums |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hair loss or growth |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Incontinence (urine or feces) | <input type="checkbox"/> Eye Sight | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Easing Bruising | <input type="checkbox"/> Breasts | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Frequent Falling |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Losing height |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Depression | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Frequent Nausea or Vomiting | <input type="checkbox"/> Infertility | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Weight loss or gain |
| | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stress | |

Other health problems (describe)

Section 4: GYNECOLOGIC HISTORY

How would you describe your current menstrual status?

- Perimenopause (before menopause, having regular periods)
- Perimenopause/menopause transition, (changes in periods, but have not gone 12 months in a row without a period)
- Post menopause (after menopause)

Was your menopause

- Spontaneous ("natural")
- Surgical (removal of both ovaries)
- Due to chemotherapy or radiation therapy? Reason for therapy _____
- Other (explain) _____

Age of first menstrual period? _____

- Are your periods (or were your periods) usually regular? Yes No
- Do you have a uterus? Yes No Don't Know
- Do you have both ovaries? Yes No Don't Know
- Do you have a cervix? Yes No Don't Know

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Section 4: GYNECOLOGIC HISTORY (Continued)

If not still having periods, what was your age when you had your last period? _____

If still having periods, how often do they occur? _____

How many days does your period last? _____

Are your periods painful? Yes No If yes, how painful? Mild Moderate Severe

Do you have spotting or bleeding between periods? Yes No

Is there a recent change in how often you have periods? Yes No

Is there a recent change in how many days you bleed? Yes No

Has your period recently become very heavy? Yes No

Do you think you have a problem with your period? Yes No

If yes, explain _____

Do you have any problems with PMS? (PMS is having mood swings, bloating, mood swings just prior to your period)

Yes No

Do you examine your breasts? Yes No If yes, how often? _____

Did your mother take DES when she was pregnant with you? Yes No Don't know

Do you douche? Yes No If yes, how often? _____

What is the date and results (if known) of your last test regarding:

Pap smear _____ Any abnormal pap tests? Yes No If yes, when? _____

Mammogram _____ Any breast biopsies? Yes No If yes, when? _____

Thyroid: _____ Any abnormal thyroid tests? Yes No If yes, when? _____

Cholesterol test _____ Colonoscopy: _____

Blood sugar test: _____ Sigmoidoscopy: _____

Fecal occult blood test: _____ Bone density test: _____

Section 5: OBSTETRICAL HISTORY

How many times have you been pregnant?

How many children do you have?

How many were adopted?

How old were you when your first child was born?

How old were you when your last child was born?

Please provide the number of your

Full term births: _____ Premature births: _____ Miscarriages: _____ Abortions: _____ Living children: _____

Any complications during pregnancy, delivery or postpartum? Yes No

If yes, please describe:

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Section 6: ALLERGY INFORMATION

Are you allergic to any medications? Yes No Don't know

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Do you have any other allergies? Yes No Don't know

To what?: _____ Reaction: _____

To what?: _____ Reaction: _____

Section 7: MEDICATION HISTORY

Are you currently using hormone therapy for menopause? Yes No

If no, why not?

If yes, for what reason?

Please indicate the medications and supplements (such as calcium, vitamins, herbs, soy) you are currently using. Include prescription drugs and those purchased without a prescription. Also include all hormone therapy you have used in the past, (examples include contraceptives, thyroid hormones and hormone therapy for menopause).

| Medication/Supplement | Dose | Frequency | Date Started | Date Stopped | Why Stopped |
|-----------------------|------|-----------|--------------|--------------|-------------|
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| | | | | | |

Have you used any other therapy for menopause (such as acupuncture or yoga?) Yes No

If yes, please indicate:

Section 7: MEDICATION HISTORY (Continued)

Of these, what are you currently using?

Is this therapy helpful? Yes No

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Section 8: FAMILY HISTORY

Please list family member (ie: mother, father, sister, brother, grandparent, aunt, uncle) who currently has or once had the following:

| | |
|--|---------------------------|
| High Blood Pressure: | Colorectal cancer: |
| Heart Attack (indicate age) | Ovarian Cancer: |
| Stroke (indicate age) | Other Cancer: |
| Blood problems: (including sickle cell trait) | Depression: |
| Blood clots: | Other emotional problems: |
| Bleeding tendency: | Alzheimer's disease: |
| Glaucoma: | Domestic violence victim: |
| Osteoporosis: | Domestic violence person: |
| Hip fracture | Sexual abuse victim: |
| Diabetes: | Sexual abuse person: |
| Breast cancer (indicate age): | Alcoholism: |
| | Drug abuse: |

Is there anything about your family's health history that concerns you, or that you would like to discuss?

Yes
 No
 If yes, what? _____

Section 9: PERSONAL HABITS

Do you consider your health to be:
 Excellent
 Good
 Fair
 Poor

Exercise

How often do you exercise?
 Almost daily
 Almost 3x a week
 Occasionally
 Rarely
 Never

If you exercise, what do you do? _____

For how long and how often? _____

Diet

How many meals do you consume each day? _____

Do you try to eat a special diet?
 Low fat
 Low Carbohydrate
 High Protein
 Vegetarian

What dairy products do you consume each day?

Milk How much? _____

Yogurt How much? _____

Cheese How much? _____

Other How much? _____

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Section 9: PERSONAL HABITS (Continued)

Are you lactose intolerant? (diarrhea or gastrointestinal/GI upset after dairy?) Yes No

How many servings of fruits do you consume each day? _____

How many servings of vegetables do you consume each day? _____

How many servings of soy foods do you consume each day? _____

How many servings of fish do you consume each day? _____

Tobacco Use

Do you currently smoke cigarettes? Yes No

If yes, how many per day? _____

Caffeine Use

Do you consume drinks with caffeine? (coffee, tea, soda drinks?) Yes No

If yes, how many drinks each day? _____

Alcohol & drug use

Do you drink alcohol? Yes No

If yes, how many drinks do you have each week? _____

Do you ever have a drink in the morning to get you going? Yes No

Have you ever tried to cut down on your drinking? Yes No

Have you ever felt guilty about the amount you drink? Yes No

Have you ever been an alcoholic? Yes No

Do you use illegal drugs? Yes No

Abuse

During the last year, have you been hit, slapped, kicked, or physically hurt by someone? Yes No

During the last year, has anyone ever forced you to have sexual activities? Yes No

Do you feel that you are verbally or emotionally abused by someone? Yes No

Have you had counseling for these issues? Yes No

Stress Management

What are your current major stressors or life changes in your life? _____

Any major changes in the family health during the past year? Yes No

If yes, explain: _____

How do you handle stress? Very well Moderately well Poorly

What do you do to relax?

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Section 10: 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 have hot flashes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have night sweats | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have difficulty getting to sleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have difficulty staying asleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I get heart palpitations or a sensation of butterflies in my chest or stomach | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I feel like my skin is crawling or itching | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I feel more tired than usual | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have difficulty concentrating | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My memory is poor | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I am more irritable than usual | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I feel more anxious than usual | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have more depressed moods | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I am having mood swings | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have crying spells | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have headaches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I need to urinate more often than usual | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I leak urine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have pain or burning when urinating | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have bladder infections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have uncontrollable loss of stool or gas | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My vagina is dry | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have vaginal itching | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have an abnormal vaginal discharge | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have vaginal infections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have pain during intercourse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have pain inside during intercourse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have bleeding after intercourse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I lack desire or interest in sexual activity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have difficulty achieving orgasm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My opportunity for sexual activity is limited | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My stomach feels like it is bloated or I've gained weight | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have breast tenderness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have joint pains | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Section 11: ABOUT MENOPAUSE AND HORMONE THERAPY

How do you view menopause?

- Positively:** For example, menopause means no more periods, and no more worry about contraception. Menopause marks a new life phase.

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Section 11: ABOUT MENOPAUSE AND HORMONE THERAPY (Continued)

How do you view menopause?

Negatively: For example, menopause means a loss of fertility and a loss of youth.

Other:

What concerns you about menopause?

(Please continue on the back)

What are your current views regarding hormone therapy for menopause?

Positive: Hormone therapy is appropriate for some women.

Negative: I don't support the use of hormone therapy.

What concerns you most about hormone therapy for menopause?

(Please continue on the back)

How would you rate your knowledge about menopause?

Very good

Fair

Moderately good

Little knowledge

How do you get your information about menopause (mark all that apply)

Books

Internet

Magazine

Friends

TV

Healthcare providers

Is there anything else you would like your healthcare provider to know?

Thank You!

Please note that the information you have provided will be held in the strictest confidence