MAUD
MEDICAL CLINIC

Patient Label

Pre-consultation Menopause Questionnaire

This questionnaire is intended to help you 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.

PERSONAL INFORMATION

Date: _____

Patient preferred name: _____ Pronouns: _____

Telephone number: _____ Email: _____

Primary health care provider: _____

Reason for consult/main concern(s)/symptoms:

MEDICAL HISTORY *please list all current and past medical conditions*

CURRENT MEDICATIONS *include supplements and over-the-counter medications*

ALLERGIES

GYNECOLOGIC HISTORY

Age at first menstrual period: _____ First day of last menstrual period: _____

How often do you have a menstrual period? _____

How many days does your period last? _____

Do you have heavy menstrual flow? _____

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

Do you have spotting/bleeding between periods?_____

Do you have any problems with PMS? (PMS is having mood swings, bloating, headaches just prior to your period) ❑ Yes ❑ No

Has there been a change in your cycles? If so, please describe. _____

_____

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

OBSTETRICAL HISTORY

What method(s) of birth control are you currently using?_____

How many times have you been pregnant? _____ How many children do you have? _____

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: _____

_____

SEXUAL HISTORY

Are you currently sexually active?..... ❑ Yes ❑ No
If yes, are you currently having sex with: ❑ A man (or men) ❑ A woman (or women) ❑ Both men and women
How long have you been with your current sex partner? _____
Are you in a committed, mutually monogamous relationship? .... ❑ Yes ❑ No
If no, do you use condoms (practice safe sex)?..... ❑ Yes ❑ No
Have you had any sexually transmitted infections? ..... ❑ Yes ❑ No
Do you have concerns about your sex life?..... ❑ Yes ❑ No
Do you have a loss of interest in sexual activities (libido, desire)? ❑ Yes ❑ No
Do you have a loss of arousal (tingling in the genitals or breasts; vaginal moisture, warmth)?..... ❑ Yes ❑ No
Do you have a loss of response (weaker or absent orgasm)?.... ❑ Yes ❑ No
Do you have any pain with intercourse (vaginal penetration)?.... ❑ Yes ❑ No
If yes, how long ago did the pain start? _____
Please describe the pain: ❑ Pain with penetration ❑ Pain inside ❑ Feels dry

PERSONAL HABITS

Do you currently smoke cigarettes? …….. ❑ Yes ❑ No

If yes, how many per day? _____When did you start? _____

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

If yes, how many drinks each day?_____

Do you drink alcohol?..... ❑ Yes ❑ No

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

Do you use illicit drugs?..... ❑ Yes ❑ No

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 clots:_____ Alzheimer's disease: _____

Bleeding tendency: _____ Osteoporosis: _____

Hip fracture:_____ Diabetes: _____

Breast cancer (indicate age):_____Depression:_____

Is there anything else you feel is important for us to take into consideration during your consultation?

_____

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