Women's health questionnaire

Please complete prior to your menopause consultation

Name	
Date of Birth	
Telephone Number	

What symptoms are troubling you?

What medication do you currently take?

Please complete the table below considering if and how these symptoms affect you:

Symptom	**Severity** **0 = not at all** **5 = significantly**	**Comment**
Flushes and sweats		
Sleep disturbance		
Mood problems		
Memory and concentration problems		
Bladder problems		
Vaginal problems		
Sexual problems		
Breast problems		
Aches and pains		
Other eg energy		

What previous contraception/HRT/hormonal treatments have you taken?
(Name of product and how did you get on with it?)

Menstrual history

When was your last menstrual period?

What are your periods like eg heavy/painful?

Do you have any concerns about irregular vaginal bleeding?

Please record your blood pressure:
Please record your weight (in kg)
Please record your height (in cm)
Do you smoke? No ☐ Yes ☐ If Yes, how many do you smoke a day?
Have your parents or siblings had heart disease or stroke under the age of 45? No ☐ Yes ☐
Have you had a deep vein thrombosis (DVT) or pulmonary embolus? No ☐ Yes ☐
Do you have any blood clotting illnesses or abnormalities? No ☐ Yes ☐ Do you have parents, siblings or children who have had a blood clot? No ☐ Yes ☐
Do you have a family history of breast cancer under the age of 50? No ☐ Yes ☐
Have you had a hysterectomy? No ☐ Yes ☐
Are you up-to-date with your cervical screening (smear) and breast screening? No ☐ Yes ☐

Is there anything else you want the doctor to know?