MENOPAUSE QUESTIONNAIRE

Print this worksheet and fill out questions.

Patient Name: _____ **Date:** _____

For each of the following symptoms, circle one number only:
0 if the symptoms are not present
1 if the symptoms are present but very mild (once a month)
2 if the symptoms are present and moderate (1-2 x/week)
3 if the symptoms are present and severe (daily)
4 if the symptoms are extremely severe (many times a day)

1.	Irregular menses	0 1 2 3 4
2.	Hot flashes	0 1 2 3 4
3.	Night sweats	0 1 2 3 4
4.	Insomnia	0 1 2 3 4
5.	Vaginal dryness	0 1 2 3 4
6.	Painful intercourse	0 1 2 3 4
7.	Decreased sexual arousal	0 1 2 3 4
8.	Noticeable aging of skin	0 1 2 3 4
9.	Breast tenderness	0 1 2 3 4
10.	Nipple tenderness	0 1 2 3 4
11.	Anxiety	0 1 2 3 4
12.	Irritability	0 1 2 3 4
13.	Depression	0 1 2 3 4
14.	Mood swings	0 1 2 3 4
15.	Weight gain	0 1 2 3 4
16.	Migraine headaches	0 1 2 3 4
17.	Joint pain	0 1 2 3 4
18.	Poor memory (forgetful)	0 1 2 3 4
19.	Difficulty concentrating	0 1 2 3 4
20.	Muscle weakness	0 1 2 3 4
21.	Fatigue	0 1 2 3 4
22.	Lack of motivation	0 1 2 3 4
23.	Wake up frequently or too early	0 1 2 3 4
24.	Heart palpitations	0 1 2 3 4
25.	Frequently anxious or nervous	0 1 2 3 4
	TOTAL:	