

Menopause client questionnaire

Name _____

Thank you for booking an appointment at True. To assist us, please take the time to complete the health questionnaire below. All information is confidential and will assist the clinician to provide you with the most appropriate treatment options. At the end of the questionnaire we have attached explanations for our questions.

| | Question | Answer or circle answer |
|---|---|-------------------------|
| 1 | What is your age? | |
| 2 | When was your last normal menstrual period? | |
| 3 | When having regular periods, how often did you have a period (e.g., every 3, 4, 5 weeks) | |
| 4 | Have you had any bleeding other than your normal period in the last 1-2 years (such as bleeding between periods, bleeding with sex, bleeding more than 12 months after your last menstrual period)? | YES / NO |
| 5 | When was your last Cervical Screening Test (previously known as a Pap Smear)? | |
| 6 | Have you ever had an abnormal Cervical Screening Test? | YES / NO |
| | If yes, when? | |
| 7 | Have you had any gynaecological surgery? | |
| | • hysterectomy | YES / NO |
| | • ovaries removed | YES / NO |
| | • endometrial ablation (a procedure that removes the lining of your uterus) | YES / NO |
| | • treatment for an abnormal Cervical Screening Test | YES / NO |
| | • laparoscopic treatment of endometriosis | YES / NO |
| 8 | Do you have a current sexual partner? | YES / NO |
| 9 | If you are sexually active, are you using anything for contraception? | YES / NO |
| | If yes, what method of contraception are you using? | |
| | • 'The pill' or another oral contraceptive | YES / NO |
| | • IUD | YES / NO |

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| | <ul style="list-style-type: none"> • Condoms or diaphragm | YES / NO |
| | <ul style="list-style-type: none"> • Implanon (hormone implant) | YES / NO |
| | <ul style="list-style-type: none"> • Partner had a vasectomy | YES / NO |
| | <ul style="list-style-type: none"> • Tubal ligation (tubes tied) | YES / NO |
| | <ul style="list-style-type: none"> • Other, please state: | |
| 10 | Are you experiencing any menopausal symptoms? | YES / NO |
| | If yes, please complete the questions at the end of this form. | |
| 11 | Are you currently using anything to treat menopausal symptoms? | YES / NO |
| | If yes, are you using: | |
| | <ul style="list-style-type: none"> • Hormones | YES / NO |
| | <ul style="list-style-type: none"> • Herbal remedies | YES / NO |
| | <ul style="list-style-type: none"> • Other, please state: | |
| | In the past, what treatments have you tried and how did you go with them? | |
| 12 | Have you ever had /suffer from any of the following medical illnesses? | |
| | <ul style="list-style-type: none"> • Deep vein thrombosis (DVT) or Pulmonary embolus (PE) | YES / NO |
| | <ul style="list-style-type: none"> • Breast cancer or have a positive BRCA gene | YES / NO |
| | <ul style="list-style-type: none"> • Endometrial cancer | YES / NO |
| | <ul style="list-style-type: none"> • Diabetes or gestational diabetes | YES / NO |
| | <ul style="list-style-type: none"> • High blood pressure, high blood pressure in pregnancy, pre-eclampsia, | YES / NO |
| | <ul style="list-style-type: none"> • Thyroid disease | YES / NO |
| | <ul style="list-style-type: none"> • Heart disease (including angina) or peripheral vascular disease | YES / NO |

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| • Stroke | YES / NO |
| • Osteoporosis | YES / NO |
| • Depression/anxiety/post-natal depression/pre-menstrual syndrome (PMS)/ Insomnia | YES / NO |
| • Recurrent Urinary Tract Infections (UTIs) | YES / NO |
| • Liver disease | YES / NO |
| • Polycystic ovarian syndrome | YES / NO |
| • Epilepsy | YES / NO |
| • Migraines | YES / NO |
| • Fibroids | YES / NO |

13 Do you have a family history of any of the following medical conditions?

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| • Stroke | YES / NO |
| • Heart disease | YES / NO |
| • Osteoporosis/fractures | YES / NO |
| • Dementia | YES / NO |
| • Cancer | YES / NO |

14 Are you on any prescribed medications including medicinal cannabis?

YES / NO

If yes, please list.

15 Do you have any allergies or have you had bad side effects from medications?

YES/NO

If yes, please list.

| | | |
|---|--|----------|
| 16 | Are you taking any over-the-counter medications or natural therapies? | YES / NO |
| | If yes, please list. | |
| 17 | Do you currently smoke or vape? (Please circle which) | YES / NO |
| | <ul style="list-style-type: none"> • If yes to smoking, how many cigarettes per day? • If yes to vaping, what mg/ml of nicotine, and how many ml per day? • What time is your first cigarette or vape of the day? | |
| | <ul style="list-style-type: none"> • For how many years have you smoked and/or vaped? | |
| | <ul style="list-style-type: none"> • Have you ever attempted to quit? | YES / NO |
| 18 | Do you drink alcohol? | YES / NO |
| | <ul style="list-style-type: none"> • If yes, how many standard drinks per week? <p>(1 standard drink = 1 mid-strength can of beer or 100ml of wine or 30ml nip of spirits)</p> | |
| 19 | Do you do regular exercise or physical activity? | YES / NO |
| 20 | When was your last mammogram? | |
| 21 | Have you ever had a breast problem? | YES / NO |
| | If yes, when? | |
| 22 | Have you had any screening for bowel cancer? (Faecal occult blood/stool test or colonoscopy) | YES / NO |
| 23 | Do you have any of the following risk factors for osteoporosis? If yes, please tick. | YES / NO |
| | <input type="checkbox"/> Previous fracture <input type="checkbox"/> Parent who has had a hip fracture <input type="checkbox"/> Currently smoking <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Taking oral corticosteroids, or have taken them for more than 3 months in the past <input type="checkbox"/> Type 1 diabetes <input type="checkbox"/> Long-standing untreated hyperthyroidism <input type="checkbox"/> Last period under the age of 45 <input type="checkbox"/> Coeliac disease <input type="checkbox"/> Drinking 3 or more standard drinks/day | |
| 24 | Is there any other information that you believe would be useful to share with the clinician? | |
| 25. If you are currently experiencing menopausal symptoms, please complete the following questionnaire on the following page: | | |

| Symptom | Date before treatment | Date 3 months after treatment | Date 6 months after treatment |
|--|-----------------------|-------------------------------|-------------------------------|
| Please fill in the first column using the following score: 0 = no problem; 1 = mild problem; 2 = moderate problem; 3 = severe problem | | | |
| Hot flushes | | | |
| Light headed feelings | | | |
| Headaches | | | |
| Irritability | | | |
| Depression | | | |
| Unloved feelings | | | |
| Anxiety | | | |
| Mood changes | | | |
| Sleeplessness | | | |
| Unusual tiredness | | | |
| Back ache | | | |
| Joint pain | | | |
| Muscle pain | | | |
| New facial hair | | | |
| Dry skin | | | |
| Crawling feeling under the skin | | | |
| Less sexual feelings | | | |
| Dry vagina | | | |
| Uncomfortable intercourse | | | |
| Urinary frequency | | | |
| TOTAL SCORE: | | | |

A total score of 15 or over usually indicates oestrogen deficiency.

Information on menopausal symptoms adapted from Australasian Menopause Society website www.menopause.org.au

List here any other symptoms not listed above that you have associated with menopause (e.g., brain fog, dry eyes, vulval itch)

Please see here explanations for our questions.

| | Question | Explanation. Feel free to ask your clinician more questions. |
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| 1 | What is your age? | There are differing risks for Menopause Hormone Therapy, depending on your age. Your age also helps inform us what doses might be most suitable for you. |
| 2 | When was your last normal menstrual period? | Menopause Hormone Therapy comes with continuous and cyclical options. Knowing the time since your last period allows us to discuss with you the most suitable options. |
| 3 | When having regular periods, how often did you have a period (e.g., every 3, 4, 5 weeks) | |
| 4 | Have you had any bleeding other than your normal period? | Abnormal bleeding, such as bleeding between periods, bleeding with sex and bleeding more than 12 months after your last period often needs further investigation to find out the cause. |
| 5 | When was your last Cervical Screening Test (previously known as a Pap Smear)? | If you are due, we can arrange this for you. |
| 6 | Have you ever had an abnormal Cervical Screening Test? | Having an abnormal CST in the past may dictate when your next CST is due |
| 7 | Have you had any gynaecological surgery? | If you have had a hysterectomy, you will usually only need oestrogen (and not progestogen) if you choose Menopause Hormone Therapy. However, the clinician will ask you more about this. Some people who have had their ovaries removed will need a higher dose of hormones. If you have endometriosis and have had a hysterectomy, you may need oestrogen and progestogen if you choose Menopause Hormone Therapy. Oestrogen-only Menopause Hormone Therapy may increase the risk of recurrence of endometriosis. |
| 8 | Do you have a current sexual partner? | Some people have a dry vagina with menopause which can affect comfort during sex. There are specific treatments available for this. |
| 9 | If you are sexually active, are you using anything for contraception? | You are still fertile in the perimenopause and within 1 – 2 years of your last period. Contraception at this time is essential if you are not planning a pregnancy. We can discuss contraceptive options with you. |
| 10 | Are you experiencing any menopausal symptoms? | Menopause with no symptoms does not need to be treated. |
| 11 | Are you currently using anything to treat menopausal symptoms? In the past, what treatments have you tried and how did you go with them? | There are many treatment options to treat menopausal symptoms. Your experience with previous treatments helps to guide that other options would be suitable for you. |
| 12 | Have you ever had /suffer from any of the following medical illnesses? | |
| | <ul style="list-style-type: none"> • Deep vein thrombosis (DVT) or Pulmonary embolus (PE) | Menopause Hormone Therapy could increase the risk of having another DVT. Your risk depends on what may have triggered your previous DVT. Menopause Hormone Therapy via patches or gels may still be an option. You may wish to discuss non-hormonal treatment options for menopausal symptoms. |
| | <ul style="list-style-type: none"> • Breast cancer or have a positive BRCA gene | Menopause Hormone Therapy could increase the risk of your breast cancer coming back. You may wish to discuss non-hormonal treatment options for menopausal symptoms. |
| | <ul style="list-style-type: none"> • Endometrial cancer | The safety of Menopause Hormone Therapy after endometrial cancer is not known. You may wish to discuss non-hormonal |

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| | treatment options for menopausal symptoms. If you are considering Menopause Hormone Therapy we may need to involve your gynaecologist or oncologist. |
| <ul style="list-style-type: none"> • Diabetes or gestational diabetes | In people with diabetes, the drop in oestrogen levels during menopause may cause sugar levels to rise, and hot flushes can feel like hypos. You may need to check your blood glucose more frequently. Menopause Hormone Therapy is a safe treatment for most diabetic people. |
| <ul style="list-style-type: none"> • High blood pressure, high blood pressure in pregnancy, pre-eclampsia, | Women with high blood pressure can still usually take Menopause Hormone Therapy and it is safe to take blood pressure lowering medication with Menopause Hormone Therapy. Extra monitoring of blood pressure may be required. You may wish to discuss non-hormonal treatments for menopausal symptoms, as one of these options can also reduce blood pressure. |
| <ul style="list-style-type: none"> • Thyroid disease | If you take thyroxine, oral oestrogen can decrease the amount of thyroxine in your blood stream. We recommend you have a blood test to check your thyroid levels about 6 weeks after starting oestrogen and after any dose changes. |
| <ul style="list-style-type: none"> • Heart disease (including angina) or peripheral vascular disease | If you have a history of coronary artery disease, Menopause Hormone Therapy may not be an option for you. You may wish to discuss non-hormonal treatments for menopausal symptoms. The presence of risk factors for heart disease is not a contra-indication to taking Menopause Hormone Therapy, but you may need further tests. |
| <ul style="list-style-type: none"> • Stroke | After a stroke, or if you have risk factors for a stroke, you may not be able to take Menopause Hormone Therapy tablets, but other forms like patches, gels or vaginal cream might be possible. You may wish to discuss non-hormonal treatments for menopausal symptoms. |
| <ul style="list-style-type: none"> • Osteoporosis | The menopausal transition is associated with bone loss due to the drop in oestrogen levels. There are various treatment options for osteoporosis, including Menopause Hormone Therapy. |
| <ul style="list-style-type: none"> • Depression/anxiety/post-natal depression/pre-menstrual syndrome (PMS)/ Insomnia | Having a history of depression, anxiety, post-natal depression, pre-menstrual syndrome (PMS) and insomnia increases the likelihood of depression, anxiety or insomnia around the time of menopause. A variety of hormonal and non-hormonal treatment options may be suitable for you. |
| <ul style="list-style-type: none"> • Recurrent Urinary Tract Infections (UTIs) | Vagina and urinary changes occur in menopause, largely due to decreasing levels of oestrogen. This can contribute to recurrent urinary tract infections. Various menopause treatment can help with your symptoms. |
| <ul style="list-style-type: none"> • Liver disease | Hormones, particularly tablets, are broken down in the liver. Many medications cannot be taken in acute liver failure. However, most treatment options for menopause are appropriate if you have mild liver disease. |
| <ul style="list-style-type: none"> • Polycystic ovarian syndrome | Most people with PCOS can safely take Menopause Hormone Therapy. Your options may depend on other risk factors for heart disease. |
| <ul style="list-style-type: none"> • Epilepsy | Some antiepileptic medications can decrease levels of estrogen and progestogens. Estrogen can increase the risk of seizures in some women and decrease the levels of Lamotrigine. Progestogens can decrease the risk of seizures. Epilepsy also increases the risk of lower bone density and increases the chance of earlier menopause. Seizures may get worse in perimenopause. You may wish to try non-hormonal treatments for menopausal symptoms before trialling Menopausal Hormonal Therapy. |

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| | <ul style="list-style-type: none"> • Migraines | Hormone fluctuations around the time of menopause can sometimes make migraines worse. Options for menopausal symptom treatment for migraine sufferers include oestrogen patches or gels, and antidepressants. |
| | <ul style="list-style-type: none"> • Fibroids | Uterine fibroids can cause heavier period bleeding, and usually shrink after menopause. You may need further investigation if you have a history of fibroids or fibroids are suspected. |
| 13 | Do you have a family history of medical conditions? | Having a family history of stroke, heart disease, cancers, dementia and osteoporosis may pose some risks to you. Often Menopause Hormone Therapy does not put you at greater risks of developing these conditions despite having a positive family history. You may wish to discuss non-hormonal treatment options for menopausal symptoms. |
| 14 | Are you on any prescribed medications including medicinal cannabis? | Some medications can reduce the effects of hormones or cause safety concerns when combined with other medications. |
| 15 | Do you have any allergies or have you had bad side effects from medications? | This will help guide what treatment options are available for you. |
| 16 | Are you taking any over-the-counter medications or natural therapies? | Some over-the-counter medications can reduce the effects of hormones or cause safety concerns when combined with other medications. |
| 17 | Do you currently smoke or vape? | Nicotine increases blood pressure and heart rate. Smoking is a risk factor for cardiovascular disease and blood clots. Many of the toxins in cigarettes are also found in the vapor from e-cigarettes. |
| 18 | Do you drink alcohol? | Drinking alcohol increases the risk of breast cancer and can cause damage to the liver. It can also decrease the strength of your bones. |
| 19 | Do you do regular exercise or physical activity? | Exercise is an important part of a healthy lifestyle and may improve some of the symptoms associated with menopause. It can also lower your blood pressure and cholesterol. |
| 20 | When was your last mammogram? | Menopause Hormone Therapy can increase breast density. If you are due for a screening mammogram, you may wish to organise this before starting Menopause Hormone Therapy. |
| 21 | Have you ever had a breast problem? | Menopause Hormone Therapy can cause breast soreness and lumpiness. It is important to know whether you have had breast problems if you are considering Menopause Hormone Therapy. |
| 22 | Have you had any screening for bowel cancer? (Faecal occult blood/stool test or colonoscopy) | This is a general screening question. National bowel cancer screening is available to people aged 50 -74. |
| 23 | Do you have any of the following risk factors for osteoporosis? | The menopausal transition is associated with bone loss due to the drop in oestrogen levels. There are various treatment options which can help prevent osteoporosis, including Menopause Hormone Therapy. |
| 24 | Is there any other information that you believe would be useful to share with the clinic doctor? | |
| 25. Menopause symptoms - If you are currently experiencing menopausal symptoms, completing a score sheet now gives us the opportunity to rescore your symptoms again 6-12 weeks after starting treatment or changes in dosing. | | |