Patient Name____________________ **DOB**_______________ **MRN**__________

Prior to your consultation, we would be grateful if you could please fill in this questionnaire which will provide us with important information in advance of your appointment.

What are your most bothersome menopausal symptoms? Give a brief outline below.

Are you currently on any treatment for your symptoms?

Has it improved your symptoms? YES ☐ NO ☐

Have you had any side effects? YES ☐ NO ☐

When did your symptoms first start to occur?

Allergies____________________

Have you or any of your close family members have had any of the following health issues. Please tick which is appropriate

	You	**Family i.e mother/sister/father etc**
Heart attack		
Heart disease/angina		
Stroke		
Blood clot		
High cholesterol or High blood pressure		
Osteoporosis		
Migraines		
Breast/ovarian/uterine cancer		

Patient Name________________________________**DOB**_______________________**MRN**____________

Lifestyle

- Do you smoke? If so what do you smoke and how much? ______________________________
- Do you exercise? If so what type and how often? ______________________________
- Do you drink alcohol? If so how many units a week? ______________________________
- Do you take recreational drugs? ______________________________
- Is your diet high in sugar? ______________________________

Bone health

- Have you had a DEXA scan? ______________________________
- Have you ever broken a bone? ______________________________
- Did either of your parents break a hip? ______________________________
- Did you ever have long term steroid treatment? ______________________________

Breast Cancer risk assessment

- Any personal history of breast cancer? ______________________________
- What age were you when you had your first baby if any? ______________________________
- Have you ever had a breast biopsy? ______________________________
- Did any member of your family have breast cancer? If so at what age where they diagnosed?

  ____

Gynaecological history

- What age did you get your first period? ______________________________
- Are you currently getting periods? ______________________________
- Have your periods changed? ______________________________
- What was/is your period pattern like? Regular or irregular? Heavy or painful?

  ____

  ____
- What age did your periods stop? ______________________________
- Any history of PMS? ______________________________
- Any history of endometriosis? ______________________________
- Previous pregnancies?

  ____

  ____

- Any history of miscarriage?

  ____

- Any history of fertility treatment?

  ____

  ____

- Any history of postnatal depression?

  ____

- Have you had regular smears and are they normal or abnormal?

  ____

What contraception have you used in the past?

- ☐ Combined oral contraceptive pill (COCP)
- ☐ Contraceptive patch (Evra)
- ☐ Vaginal ring (NuvaRing)
- ☐ Progesterone only pill
- ☐ Progesterone injection (DEPO-Provera)
- ☐ Implanon
- ☐ Mirena coil
- ☐ Copper Coil/ Ballerine
- ☐ Kyleena or Jaydess
- ☐ None

Did you have any problems with contraception?

____

Are you sexually active? ______________________________

Have you ever seen a womens health physio? ______________________________

Please continue on to the next page to complete the final part of the questionnaire. Please tick which box is appropriate for you
Please bring a list of your current medication to your appointment

NB: Please bring this consultation form with you to your appointment or return by email or post prior to your appointment

Postal Address
The CUMH Complex Menopause Clinic,
Lee clinic,
Lee road,
Mount Desert,
Cork
T 23 KV2K

Email: CUMH.ComplexMeno@hse.ie

Patient Name____________________________________**DOB**__________**MRN**______________________

Physical	**Yes**	**No**
Headache		
Palpitations		
Joint pains		
Aches and pains		
Burning mouth/tongue		
Dry Skin/nails/eyes/hair		
Itchy or crawling skin		
Hair loss		
Acne		
Numbness in parts of body		
Breathing difficulties		

Mood/Memory	**Yes**	**no**
Anxiety		
Feeling low		
Tearfulness		
Irritability		
Mood swings		
Bursts of anger		
Worsening PMS		
Poor memory or 'Brain Fog'		
Poor focus & concentration		
Loss of interest in most things		
Feeling excitable		

Cycle changes	**Yes**	**No**
Shorter period cycle		
lighter period cycle		
Heavier period cycle		
Bleeding in between periods		
Longer period cycle or skipped periods		

Vasomotor	**Yes**	**No**
Hot flushes		
Night sweats		

Bladder/Vaginal/GSM	**Yes**	**No**
Painful sex		
Dry or Itchy vagina		
Vaginal discharge		
Overactive bladder		
Recurrent UTIs		

Miscellaneous	**Yes**	**No**
Loss of libido		
Low energy		
Dizziness		
Tinnitus		
Poor sleep		

Please fill in questionnaire for your current symptoms

HSE
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