When a person has reached menopause, or is wondering if this is a cause of the problems being experienced, it is important to routinely ask yourself questions that allow you to know specifically what is going on. The Menopause Questionnaire will help you identify if you are in menopause based on subjective symptoms. Please remember that this questionnaire only examines your menopause based on symptoms, it is not a replacement for a healthcare professional.

These questions relate to menopause and the time period prior to menopause (known as peri-menopause). We define menopause as beginning after you have had no menstrual cycles for ONE YEAR. Peri-menopause is recognized as the several years prior to menopause and generally lasts from 2-6 years. Most women recognize peri-menopause as the time at which they begin to have irregular periods. You have been given this questionnaire because you have indicated that you are in peri-menopause or are post-menopausal.

For the following questions, please answer each question, in some questions you may need to define a scale with a score of 10 to 0; grade 10- if you have a significant issue and 0- if you don't have the issue at all.

**SECTION 1: IF YOU ALREADY HAVE BEEN DIAGNOSED WITH MENOPAUSE**

1. What was the approximate date of your last menstrual period? _______________
2. What age did your menstrual cycles first become irregular? _______________
3. What age do you think you entered peri-menopause? _______________
4. Are you post-menopausal? (Answer YES, if your last menstrual period was over one year ago?) YES NO
5. If post-menopausal, what age did you consider yourself post-menopausal? _______________
   * write N/A if not applicable
6. What happened that made you think you were in menopause? (Please check all that apply)
   - Hot flashes
   - Weight gain
   - Irregular periods
   - Shorter, lighter periods
   - Shorter cycles
   - Loss of interest in sex
   - Difficulty Sleeping
   - Low mood or depression
   - Decreased ability to concentration
   - Irritability
   - My doctor informed me that I was menopausal
   - I felt I was just at that age
   - Other (please specify below) ______________________________________________________________________

7. Have you received any medical treatment, such as a hysterectomy or chemotherapy that caused or precipitated menopause? YES NO
8. If yes, what treatment did you receive? ______________________________________________________________________
9. Did you in the past, or do you currently, take hormone replacement therapy (HRT)?
   - YES, I am currently on HRT
   - YES, I have taken HRT but do not currently
   - NO, I do not and have never taken HRT
10. If yes, has it alleviated any mood symptoms? YES NO
SECTION 2: IF YOU ARE UNSURE IF YOU ARE MENOPAUSAL OR IF YOU ARE MENOPAUSAL AND WANT TO MEASURE YOUR SYMPTOM SCORE

By doing a questionnaire every couple of months and answering the questions without looking back at what you answered the last time you did the questionnaire, you can objectively see where you have improved or where you need to pay attention.

Every four months you should evaluate your hormonal state. For the following questions answer each question with a score of 10 to 0; grade 10 if you have a significant issue that happens all the time, and 0 if you don’t have the issue at all.

1. Are you over 40 years old? Yes No
2. Are your menstrual periods irregular? Yes No Scale ________.
3. When was your Last Menstrual Period (LMP) ________________.
4. What is the length of time in between menstrual period bleeding? ________________.
5. How long does the menstrual period last? ________________.
6. If your periods have been irregular: Is this recent or has this been going on for quite a while? ________________.
7. Are you having more spotting or break-through bleeding? Yes No Scale ________.
8. Are you having hot flushes or heat intolerance in waves during the day? Yes No Scale ________.
9. Are you having hot flushes or heat intolerance in waves during the night? Yes No Scale ________.
10. Are you having night sweats and wake up with the sheets wet? Yes No Scale ________.
11. Do the night sweats interfere with your sleeping at night causing difficulty to sleep? Yes No Scale ________.
12. Are you experiencing insomnia, difficulty falling to sleep, or difficulty staying asleep? Yes No Scale ________.
13. Do you wake up multiple times when sleeping and have interrupted sleep? Yes No Scale ________.
14. Do you feel a loss of energy? Do you feel more fatigued? Yes No Scale ________.
15. Are you anemic, or think you are anemic? Yes No Scale ________.
16. Do you feel more fatigued? Are you more tired in the morning? Yes No Scale ________.
17. Are you less energetic in general? Yes No Scale ________.
18. Do you feel less motivated, less assertive, and less confident? Yes No Scale ________.
19. Do you have less muscle strength? Do you feel weaker? Yes No Scale ________.
20. Are you developing or having increased acne? Yes No Scale ________.
21. Is your voice changing and becoming deeper or more masculine? Yes No Scale ________.
22. Are you developing more facial hair (hirsutism)? Yes No Scale ________.
23. Is your pubic hair thinning? Yes No Scale ________.
24. Does it seem as though your breast are shrinking and sagging?  Yes  No  Scale ____________.
25. Are you gaining weight rapidly over the past few months?  Yes  No  Scale ____________.
26. Are you gaining more body fat? Do you feel less lean?  Yes  No  Scale ____________.
27. Are you having trouble tolerating sugars and carbohydrates?  Yes  No  Scale ____________.
28. Are you having more headaches?  Yes  No  Scale ____________.
29. Are you gaining more aches and pain? Are you starting to get arthritis?  Yes  No  Scale ____________.
30. Are you gaining more lower back pain or hip pain? Yes  No  Scale ____________.
31. Do you feel more joint pain?  Yes  No  Scale ____________.
32. Do you seem to be getting more inflammations and swellings?  Yes  No  Scale ____________.
33. Are you developing new allergies or asthma or are your allergies or asthma getting worse?  Yes  No  Scale ____________.
34. Do you feel less motivated in general? Do you feel less assertive? Yes  No  Scale ____________.
35. Are you feeling more depressed or withdrawn or isolated?  Yes  No  Scale ____________.
36. Are you feeling frightened or afraid? Yes  No  Scale ____________.
37. Are you feeling more irritable? Yes  No  Scale ____________.
38. Do you feel periods of hopelessness? Yes  No  Scale ____________.
39. Are you having more mood swings? Yes  No  Scale ____________.
40. Are you experiencing more anxiety? Do you feel more anxious? Yes  No  Scale ____________.
41. Do you feel less composed and out of control? Yes  No  Scale ____________.
42. Are you having increased vaginal pain, dryness or itching? Yes  No  Scale ____________.
52. Are you having trouble with your memory? Do you feel like you are having more trouble remembering names? Are you more forgetful? Yes No Scale ____________.

53. Do you feel your mental skills are diminishing? Yes No Scale ____________.

54. Are you experiencing times of mental fogginess, or trouble thinking clearly? Yes No Scale ____________.

55. Are you having more trouble remembering things and events? Yes No Scale ____________.

56. Are you experiencing more confusion? Yes No Scale ____________.

57. Are you having trouble controlling your urine? Yes No Scale ____________.

58. Do you have to urinate more often than in the past? Yes No Scale ____________.

59. Do you spill or leak urine when you cough or sneeze? Yes No Scale ____________.

60. Are you feeling like you are having more twitches and spasms? Yes No Scale ____________.

61. Are you noticing more wrinkles around your mouth and eyes? Yes No Scale ____________.

62. Is the skin tone on your arms, legs, or hands poor? Yes No Scale ____________.

63. Has the skin lost its firmness or fullness? Yes No Scale ____________.

64. Do you cry more easily, or more often? Yes No Scale ____________.

65. Are your hands or feet colder? Yes No Scale ____________.

Now that you have answered these questions add up your grade. The higher your grade is, the more likely that you have a hormonal imbalance problem and you should consult with your health care provider.

If your grade is higher than 200 or higher: It is very likely that you have a significant hormonal issue. It is also likely that the problem is causing other problems that could be treated and improved if hormonal balance is achieved. Please visit your doctor and have a conversation about your complaints and get checked. It is likely that you may need to have to get tested.

If your score is between 150 and 200: You likely have a noticeable hormonal problem, and your reproductive system may be struggling. It is a good idea to consider visiting your doctor and getting the checked.

If your score is between 50 and 150: Your hormonal system is showing some wear and tear, and you should consider not only your hormones but other conditions that could be affecting your health. Consider your lifestyle and implement corrective measures in areas that you consider appropriate: Diet, exercise, caffeine, alcohol, and stress. Consider visiting your physician for a comprehensive review of your health.

If you scored less than 50: Your hormonal system is in good condition.

I suggest you do this questionnaire on a regular basis and hopefully gain insight to your health and wellbeing.

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