Menopause HEALTH

Name:	
Date of Birth:	

Past Medical History:		
	Yes	No
Previous blood clot (DVT/ PE)	☐	☐
Cardiac disease/previous heart attack or stroke	☐	☐
High blood pressure	☐	☐
Atrial Fibrillation (irregular heart beat)	☐	☐
Previous fracture	☐	☐
Diabetes	☐	☐
Chronic Kidney Disease	☐	☐
Migraine	☐	☐
Rheumatoid Arthritis	☐	☐
Systemic Lupus Erythrematosus (SLE)	☐	☐
Breast cancer	☐	☐
Ductal Carcinoma In Situ	☐	☐
Lobular Carcinoma In Situ	☐	☐
BRCA 1 or BRCA 2 gene positive	☐	☐
Previous breast biopsy for benign (non cancerous) condition	☐	☐
Previous Hysterectomy	☐	☐

Smoking Status:	
Nonsmoker	☐
Exsmoker (> 1 year)	☐
< 10 per day	☐
> 10 per day	☐

Family History:		
	Yes	No
Angina/Heart Attack in first degree relative (parent, child or sibling) under the age of 60	☐	☐
Parent who had a hip fracture	☐	☐
First degree relative who had breast cancer	☐	☐

Previous results (if known):	
Total Cholesterol:	
Cholesterol/ HDL ratio:	
Height (cm):	
Weight (kg):	

Gynaecological History:	
Number of pregnancies (if any)	
Number of live births	
Your age when your first child was born	
Age at time of your first period	
Age at time of your most recent period	

Current Medications:
Medication Allergies:

	Quality of Life Questionnaire	1	2	3	4	5
1	I am able to control things in my life that are important to me	☐	☐	☐	☐	☐
2	My mood is generally good	☐	☐	☐	☐	☐
3	I frequently experience anxiety	☐	☐	☐	☐	☐
4	I feel challenged by my work	☐	☐	☐	☐	☐
5	I am not content with my sexual life	☐	☐	☐	☐	☐
6	I currently experience physical discomfort or pain during sexual activity	☐	☐	☐	☐	☐
7	I am content with the frequency of my sexual interactions with a partner	☐	☐	☐	☐	☐
8	I am proud of my occupational accomplishments	☐	☐	☐	☐	☐
9	I consider my life stimulating	☐	☐	☐	☐	☐
10	I feel physically well	☐	☐	☐	☐	☐
11	I feel physically fit	☐	☐	☐	☐	☐
12	I continue to set personal goals for myself	☐	☐	☐	☐	☐
13	I continue to set occupational goals for myself	☐	☐	☐	☐	☐
14	I expect that good things will happen in my life	☐	☐	☐	☐	☐
15	I feel in control of my eating behaviour	☐	☐	☐	☐	☐

1 = Not True of me
3 = Moderately True
5 = Very True of me

Menopause HEALTH

Patient Health Questionnaire (PHQ-9)		
Over the last two weeks, how often have you been bothered by any of the following problems?		Score
Little interest or pleasure in doing things?	0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly every day	0
Feeling down, depressed, or hopeless?	0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly every day	0
Trouble falling or staying asleep, or sleeping too much?	0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly every day	0
Feeling tired or having little energy?	0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly every day	0
Poor appetite or overeating?	0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly every day	0
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly every day	0
Trouble concentrating on things, such as reading the newspaper or watching television?	0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly every day	0
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly every day	0
Thoughts that you would be better off dead, or of hurting yourself in some way?	0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly every day	0
Total =		0
Depression Severity: 0-4 none, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe.		