**MENOPAUSE SYMPTOM QUESTIONNAIRE**

Please use this questionnaire to record any symptoms you may be experiencing for further discussion with your health professional

Please put the score (0 – 5) that best describes your symptoms in the ‘your score’ column.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **Not at all** | | **Rarely** | | **Less than half the time** | | **About half the time** | **More than half the time** | | **Always** | | **YOUR SCORE** | |
| **Psychological and Emotional symptoms:** Over the past 3 months have you noticed any changes in your mood, being more irritable or anxious, changes to your confidence or memory? | | 0 | | 1 | | 2 | | 3 | 4 | | 5 | |  | |
| **Vulva/ vaginal symptoms:** over the last 6 months, have you experienced any irritation, dryness or soreness or discharge in the vulva (outside part of female genitals) or vagina? | | 0 | | 1 | | 2 | | 3 | 4 | | 5 | |  | |
| **Urinary symptoms:** Has there been a change in the way you urinate (pass water) to more frequent or more urgently? | | 0 | | 1 | | 2 | | 3 | 4 | | 5 | |  | |
| **Symptoms around sex:** Has intercourse (having sex) or smear tests been more painful or caused any bleeding? | | 0 | | 1 | | 2 | | 3 | 4 | | 5 | |  | |
| **Physiological Symptoms:** Have you experienced any of the following symptoms in the last 3 months: Palpitations- or your heart racing fast, sweats, flushing, night sweats, unable to sleep, headaches joint pains, tiredness or stomach bloating | | 0 | | 1 | | 2 | | 3 | 4 | | 5 | |  | |
| **Bleeding or Period symptoms:** Have you experienced changes to your bleeding pattern with spotting, irregular, heavy or missed periods | | 0 | | 1 | | 2 | | 3 | 4 | | 5 | |  | |
| **Insert total menopause symptom score in the box to the right:**  *(0-6 mild; 7-18 moderate; 19-30 severe symptoms)* | | | | | | | | | | | | |  | |
| **These symptoms are affecting my:** | **never** | | **rarely** | | **sometimes** | | **often** | | | **always** | | **YOUR SCORE** | |
| **Ability to work** | 0 | | 1 | | 2 | | 3 | | | 4 | |  | |
| **Relationships** | 0 | | 1 | | 2 | | 3 | | | 4 | |  | |
| **Enjoyment in life** | 0 | | 1 | | 2 | | 3 | | | 4 | |  | |

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| --- |
| What is the most important thing you want to discuss? |
| *(Free text box)* |

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please take this questionnaire with you, or hand in to the surgery ahead of your appointment to discuss your symptoms with your general practice team.

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