Menopause Society

OF IRELAND

Menopause Pre Consult

Patient Name: _____

D.O.B: _____

Please bring this consultation form with you to your appointment, or you can email or post it prior to your appointment

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Patient Name_____**DOB**_____

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		

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Patient Name_____**DOB**_____ _____

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?

  _____

Cardiovascular Health

- Do you ever had high blood pressure?

_____

- Have you had any heart problem?

_____

- Have you seen a cardiologist or had any heart investigation

_____

- Have you ever had a blood clot?

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 in the past with contraception?

Are you sexually active? If so is there any pain/burning / discomfort?

Have you ever seen a women's health physio?

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Please continue on to the next page to tick your current symptoms.

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

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

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

Vasomotor	Yes	No
Hot flushes		
Night sweats		

Please fill in questionnaire for your current symptoms

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