

PERIMENOPAUSE QoL QUESTIONNAIRE



Perimenopause brings a range of physical, sexual, emotional and cognitive changes that can be as confusing as they are challenging. Many of these symptoms are commonly dismissed as part of normal ageing, which leads some women to experience them quietly – often feeling alone, misunderstood, or even reluctant to speak up. But these symptoms are real and they deserve to be acknowledged with compassion and care.

Completing the following questionnaire will help your practitioner better understand where you may be in your menopausal transition and how best to support you throughout the journey.

NAME: _____

DATE: _____

HEALTH HISTORY

Have you ever been diagnosed with any of the following:

Endometriosis ☐ Yes ☐ No Adenomyosis ☐ Yes ☐ No Polycystic Ovarian Syndrome ☐ Yes ☐ No

Uterine Fibroids ☐ Yes ☐ No Uterine Polyps ☐ Yes ☐ No Pelvic Inflammatory Disease ☐ Yes ☐ No

Interstitial Cystitis ☐ Yes ☐ No Pelvic Organ Prolapse ☐ Yes ☐ No

Cervical, ovarian, uterine or breast cancer: ☐ If yes, please specify which & when: _____ ☐ No

Have any members of your immediate family been diagnosed with any of the above? ☐ Yes ☐ No

If yes, which one/s? _____

History of urinary tract infections? ☐ Yes ☐ No History of candida overgrowth? ☐ Yes ☐ No

Have you been diagnosed with any sexually transmitted diseases? ☐ Yes ☐ No

If yes, please specify: _____

Do you have any of the following:

Type 2 Diabetes ☐ Yes ☐ No Insulin resistance ☐ Yes ☐ No Cardiovascular disease ☐ Yes ☐ No

High blood pressure ☐ Yes ☐ No High cholesterol ☐ Yes ☐ No

Metabolic Associated Fatty Liver Disease ☐ Yes ☐ No

Have you had any surgeries? ☐ Yes ☐ No If yes, please provide details on type of surgery and approximately when it occurred: _____

Do you take any nutritional or herbal supplements? ☐ Yes ☐ No

If yes, please specify: _____

Would you consider yourself generally a well person with good vitality? ☐ Yes ☐ No

MENSTRUAL HISTORY

When menstruating, have your cycles usually been regular? ☐ Yes ☐ No

Heavy or light periods? _____

How have they changed recently? ☐ Longer cycle ☐ Shorter cycles ☐ Heavy flow ☐ Light flow

Any clotting? ☐ Yes ☐ No If so, how large – could you compare their size to a coin? _____

Any breast pain? ☐ Yes ☐ No Depression or anxiety? ☐ Yes ☐ No

Is there a regular history of premenstrual syndrome leading up to your monthly periods? ☐ Yes ☐ No

Continued...

MENSTRUAL HISTORY *(continued...)*

Do you currently use or have a history of using any of the following:

Oral contraceptive pill ☐ Yes ☐ No Hormonal IUD such as Mirena ☐ Yes ☐ No

Contraceptive injectable (Depo-Provera) ☐ Yes ☐ No Contraceptive implant (Implanon) ☐ Yes ☐ No

MENOPAUSAL HORMONE THERAPY

Have you been prescribed menopausal hormone therapy? ☐ Yes ☐ No

If so, what are those treatments: _____

How long have you been taking them for: _____

Do you feel they are helping? ☐ Yes ☐ No

If not, please describe the ongoing symptoms: _____

Aside from MHT, are you currently on other prescription medication? ☐ Yes ☐ No

If yes, please specify: _____

CURRENT PHYSICAL, COGNITIVE & EMOTIONAL AND SEXUAL CONCERNS

How long have you been experiencing perimenopausal symptoms? _____

For each of the following, tick the box that best describes your experience for each symptom below:

PHYSICAL SYMPTOMS:	Never	Rarely	Sometimes	Regularly	Currently
Hot flushes (feeling waves of heat)	☐	☐	☐	☐	☐
Night sweats	☐	☐	☐	☐	☐
Muscle and joint pains (including backache)	☐	☐	☐	☐	☐
A racing or pounding heart	☐	☐	☐	☐	☐
Headaches or migraines	☐	☐	☐	☐	☐
Tinnitus (ringing in the ears)	☐	☐	☐	☐	☐
Breast pain or tenderness	☐	☐	☐	☐	☐
Itchy skin	☐	☐	☐	☐	☐
A crawling feeling under the skin	☐	☐	☐	☐	☐
Dry skin	☐	☐	☐	☐	☐
Acne	☐	☐	☐	☐	☐
Dry vagina	☐	☐	☐	☐	☐
Vaginal itching, burning and irritation	☐	☐	☐	☐	☐
Deep pelvic pain or pressure	☐	☐	☐	☐	☐
Increased urinary urgency and frequency	☐	☐	☐	☐	☐
Incontinence	☐	☐	☐	☐	☐
Urinary tract infections	☐	☐	☐	☐	☐

PHYSICAL SYMPTOMS:	Never	Rarely	Sometimes	Regularly	Currently
Irregular periods	☐	☐	☐	☐	☐
Fluid retention	☐	☐	☐	☐	☐
Constipation	☐	☐	☐	☐	☐
New facial or body hair	☐	☐	☐	☐	☐
Thinning hair	☐	☐	☐	☐	☐
Weight gain	☐	☐	☐	☐	☐
Fatigue/tiredness	☐	☐	☐	☐	☐
COGNITIVE & EMOTIONAL SYMPTOMS:	Never	Rarely	Sometimes	Regularly	Currently
Brain fog (difficulty concentrating)	☐	☐	☐	☐	☐
Forgetfulness/poor memory	☐	☐	☐	☐	☐
Loss of interest in most things (feeling numb, indifferent, or detached)	☐	☐	☐	☐	☐
Feelings of rage	☐	☐	☐	☐	☐
Fluctuating moods	☐	☐	☐	☐	☐
Anxiety / increasing anxiety	☐	☐	☐	☐	☐
Panic	☐	☐	☐	☐	☐
Depression/low mood	☐	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	☐
Feelings of being unloved	☐	☐	☐	☐	☐
Feelings of overwhelm	☐	☐	☐	☐	☐
Struggling with confidence and self-esteem	☐	☐	☐	☐	☐
SEXUAL HEALTH:	Never	Rarely	Sometimes	Regularly	Currently
Less sexual desire	☐	☐	☐	☐	☐
Pain during sex / uncomfortable intercourse	☐	☐	☐	☐	☐
Reduced libido, arousal and orgasm	☐	☐	☐	☐	☐
Bleeding during or after intercourse	☐	☐	☐	☐	☐
Tearing during intercourse	☐	☐	☐	☐	☐
SLEEP-RELATED SYMPTOMS:	Never	Rarely	Sometimes	Regularly	Currently
Difficulty falling asleep	☐	☐	☐	☐	☐
Restless legs	☐	☐	☐	☐	☐
Racing thoughts	☐	☐	☐	☐	☐
Waking during the night	☐	☐	☐	☐	☐
Waking unrefreshed	☐	☐	☐	☐	☐

DIET

How often do you reach for alcohol during the week? _____

Do you use it for stress relief? ☐ Yes ☐ No ☐ Sometimes

Do you notice any reactions after drinking alcohol? **ie. poor sleep, sniffly nose or hayfever symptoms, itchy or red skin** ☐ Yes ☐ No ☐ Sometimes

How many coffees do you consume in a day? _____ List any reactions: _____

DIET (continued...)

Do you crave sugar and/or coffee in the afternoons? ☐ Yes ☐ No ☐ Sometimes

How often do you eat processed or fast foods? ☐ Rarely ☐ Regularly

How much water do you drink per day? _____ Do you feel you're drinking enough? ☐ Yes ☐ No

LIFESTYLE

On average, how often and how long do you exercise? _____

Do you engage in resistance/strength training? ☐ Yes ☐ No If yes, how many times per week? _____

Do you engage in high intensity exercise? ☐ Yes ☐ No If yes, how many times per week? _____

What kind of exercise do you enjoy most? _____

How would you rate your stress levels? 1 = low, 10 = extreme _____

What are the biggest stressors in your life? _____

Do you feel you manage work/life balance well? ☐ Yes ☐ No

Do you have regular social interactions? ☐ Yes ☐ No

What do you find helps or hinders your sleep? _____