MEDICAL CLINIC AT SOUTHPOINTE

MENOPAUSE PRE-SCREENING FORM

Name:

Phone:

Please indicate how bothered you are now and in the past few weeks by any of the following :

Questions	Rating Scale			
	Not at all	**A little bit**	**Quite a bit**	**Extremely**
I have hot flashes	☐	☐	☐	☐
I have night sweats	☐	☐	☐	☐
I have difficulty getting to sleep	☐	☐	☐	☐
I get heart palpitations or a sensation of butterflies in my chest or stomach	☐	☐	☐	☐
I feel like my skin is crawling or itching	☐	☐	☐	☐
I feel more tired than usual	☐	☐	☐	☐
I have difficulty concentrating	☐	☐	☐	☐
My memory is is poor	☐	☐	☐	☐
I am more irritable than usual	☐	☐	☐	☐
I feel more anxious than usual	☐	☐	☐	☐

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Please indicate how bothered you are now and in the past few weeks by any of the following :

Questions	Rating Scale			
	Not at all	**A little bit**	**Quite a bit**	**Extremely**
I have more depressed moods	☐	☐	☐	☐
I am having mood swings	☐	☐	☐	☐
I have crying spells	☐	☐	☐	☐
I have headaches	☐	☐	☐	☐
I need to urinate more often than usual	☐	☐	☐	☐
I leak urine	☐	☐	☐	☐
I have pain or burning when urinating	☐	☐	☐	☐
I have bladder infections	☐	☐	☐	☐
I have uncontrollable loss of stool or gas	☐	☐	☐	☐
My vagina is dry	☐	☐	☐	☐
I have vaginal itching	☐	☐	☐	☐

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Please indicate how bothered you are now and in the past few weeks by any of the following :

Questions	Rating Scale			
	Not at all	**A little bit**	**Quite a bit**	**Extremely**
I have an abnormal vaginal discharge	☐	☐	☐	☐
I have vaginal infections	☐	☐	☐	☐
I have pain during intercourse	☐	☐	☐	☐
I have pain inside during intercourse	☐	☐	☐	☐
I lack desire or interest in sexual activity	☐	☐	☐	☐
I have difficulty achieving orgasm	☐	☐	☐	☐
My opportunity for sexual activity is limited	☐	☐	☐	☐
My stomach feels like it's bloated or I've gained weight	☐	☐	☐	☐
I have breast tenderness	☐	☐	☐	☐
I have joint pains	☐	☐	☐	☐