AVENUE MENOPAUSE CLINIC

Patient Name: _____DOB: _____

Patient Questionnaire	
Are you having regular periods? **If Yes:** -Have your cycles changed? How? -What is the variation between your shortest and longest cycle? E.g. 25-31 days. -Are your periods heavy or painful? -Do you bleed between cycles or after intercourse? **If No:** When was your last period?	
2: When was your last smear? -Have you ever had an abnormal smear?	
3: Do you have any other gynaecological history e.g. ovarian cysts/endometriosis?	
4: Are you using contraception? If so, what?	
5: Do you have any significant medical history?	
6: Do any of your parents or siblings have a history of breast, ovarian or bowel cancer?	
7: Have you ever had a mammogram? If so, was it normal?	
8: Have you ever broken a bone?	

9: Do any of the following apply to you? ☐ Long-term steroid use (more than 6 months) ☐ History of anorexia or significant weight loss? ☐ Family history of osteoporosis ☐ Coeliac disease or inflammatory bowel disease 10: Do you exercise? If so, how often and what type of exercise?	
11: Do you smoke? If so, how many and for how many years?	
12: Have you ever had a heart attack or a stroke?	
13: Have your parents of siblings every had a heart attack or stroke? If so, at what age?	
14: Do you have high blood pressure, high cholesterol or diabetes?	
15: Have you ever had a clot in your legs or lungs?	
16: Have your parents or siblings every had a clot in their legs or lungs?	
17: Do you get migraines? If so, are they related to menstruation? What do you take for them?	