Perimenopause/Menopause Consult

DR KATE BRUNSDON

When was your last menstrual period?

____

How would you describe your menstrual periods?

____

Have they changed recently?

____

Do you use contraception?

____

If yes, what type?

____

Do you have a history of:
(Please tick all applicable)

Breast Cancer ....
Endometrial Cancer ....
Ovarian Cancer ....
Blood Clots ....
Heart Disease ....
Stroke/TIA ....
High Blood Pressure ....
Osteoporosis/Osteopaenia ....
Liver Disease ....
Migraine with Aura ....
Depression or Anxiety ....
Premenstrual Syndrome/PMDD ....
Endometriosi ....
Recurrent UTIs ....
Hysterectomy ....
Oophorectomy ....

SYMPTOM SCORE (Modified Greene Scale)
SEVERITY OF PROBLEM IS SCORED AS FOLLOWS
SCORE: None =0; Mild =1; Moderate =2; Severe =3

Hot flushes ______________
Light headed feelings ______________
Headaches ______________
Brain fog ______________
Irritability ______________
Depression ______________
Unloved feelings ______________
Anxiety ______________
Mood changes ______________
Sleeplessness ______________
Unusual tiredness ______________
Backache ______________
Joint pains ______________
Muscle pains ______________
New facial hair ______________
Dry skin ______________
Crawling feelings under the skin ______________
Less sexual feelings ______________
Dry vagina ______________
Uncomfortable intercourse ______________
Urinary frequency ______________

TOTAL ______________