CENTER FOR ALTERNATIVE MEDICINE

PATIENT QUESTIONNAIRE

Am I Going Through Menopause?

Name _____ Date _____

Read the sentences below and check "**yes**" for the ones that apply to you. Check "**no**" for the ones that do not apply to you.

CHANGES IN YOUR PERIOD

	YES	NO
Sometimes my cycle is shorter than usual	☐	☐
I occasionally bleed between my periods	☐	☐
I'm having my period a lot more than usual	☐	☐
I'm hardly having periods	☐	☐

HOT FLASHES

	YES	NO
I suddenly begin to sweat	☐	☐
My face becomes very red and hot	☐	☐
I wake up in the middle of the night drenched in sweat	☐	☐
Hot drinks and alcohol make me very hot and uncomfortable	☐	☐

DRYNESS

	YES	NO
Sex is sometimes painful and dry	☐	☐
I have vaginal itching and irritation but no infection	☐	☐

BLADDER PROBLEMS

	YES	NO
I always feel like I have to urinate, even if I don't	☐	☐
I leak urine when I sneeze or cough	☐	☐
The need to urinate wakes me from my sleep	☐	☐

MOOD SWINGS

	YES	NO
I feel so old	☐	☐
I can't catch up on my sleep; I'm always tired	☐	☐
I'm cranky and little things annoy me	☐	☐