## MENOPAUSAL ASSESSMENT TOOL

Date______________

Name_________________________________Occupation____________________________________
Age____ Race____ Weight____ Height____ Loss of height noted? If yes, how much________________
Is your arm span equal to your height?____ Body frame: Small____ Medium____ Large____
Are you of European descent?____

### CHIEF COMPLAINT

Reason for visit_______________________________________________________________________
Have you had any bone fractures? Back____ Wrist____ Hip____ Any menopausal symptoms?________
______________________________________________________________________________________
How does your chief complaint interfere with your daily living?___________________________________

### RELATED SYMPTOMS

____Malaise ____Weight loss ____Gait (unable to work) ____Peridontal changes ____Depression
____Back deformities (rounded back, curved back or swayback, or dowager's hump)
Other__________________________________________________________________________

### RISK PROFILE

Check those that pertain to you:

____Tobacco use now
____History of smoking # of years____
____Constant dieting
____More than 2 alcohol drinks daily
____Nulliparity (no pregnancies)
____Thin, fair skinned
____Premature menopause (surgical or natural)
age____

___Postmenopausal
___History of irregular menses (age 20-40)
___History of oral contraceptives, # years used__
___Family history of ___osteoporosis
___heart disease
___breast cancer
___uterine/ovarian cancer
___Sedentary lifestyle
___Calcium deficiency

### PAST MEDICAL HISTORY

____Gum disease
____Cushing's disease
____Paralysis
____Diabetes

____Cirrhosis of liver
____High blood pressure
____Hyperparathyroidism
____Deep vein thrombosis/legs
____Gallbladder disease

MEDICATION HISTORY

____Heparin for 6 months
____Antacids with aluminum
____Corticosteroids
____Anticonvulsants
____Thyroid medication
__________________________

### MENSTRUAL HISTORY

Postmenopausal____ Age of onset____ Premature menopause (before 50)____ Ovaries removed____
Hysterectomy____ Estrogen replacement: Type___________________________ How long?_________
Use of oral contraceptives____ Date started______
Have you ever been diagnosed as estrogen deficient? Yes____ No____

### CURRENT SIGNS/ SYMPTOMS:

____Hot flashes/ sweats
____Sleep disturbances
____Heart palpitations
____Weakness or fatigue
____Anxiety or depression
____Mood swings

____Change in sexual desire
____Pain with intercourse
____Bleeding with intercourse
____Leaking of urine
____Current history of vaginal infection
____Other________________________

## NUTRITIONAL HISTORY

___Yes ___No Are you below the recommended weight for your sex, age, height?
___Yes ___No Do you consume a low fat diet?
___Yes ___No Do you consume a low calcium diet?
___Yes ___No Do you consume a high phosphorus diet? (sodas, red meat)
___Yes ___No Do you spend less than 15 minutes in the sun daily?
___Yes ___No Do you lack a tolerance for milk products?
___Yes ___No Do you consume hard water? (100 mg calcium/qt.)
___Yes ___No Do you consume soft water? (10-30 mg calcium/qt.)
Do you take a calcium/magnesium supplement?______ What kind?________________ #mg________
Do you eat foods high in calcium?____ List________________________________________________
______________________________________________________________________________
Cups of coffee/day_____ Sodas/day____

## FITNESS PROFILE

Daily exercise: Describe__________________________________________________________
Duration_____ # times/week______
Do you engage in a stress management practice?___________________________________
Duration_____ # times/week ______

## SELF-CARE PRACTICES

___Maintain adequate calcium intake (800-1500 mg/day)
___Eat yogurt, tofu, dark leafy veggies daily
___Avoid phosphorus foods (red meat, sodas)
___Weight bearing exercises daily
___Use hard water when possible
___Get 15 minutes of sun daily
___Use vinegar to prepare stock from bones
___Sleep 7- 8 hours nightly
___Avoid smoking
___Use botanicals Type_____________________________________________________________
Use minerals and vitamins Type_____________________________________________________
Monthly self breast exam__________________________________________________________
___Other_______________________________________________________________________

## SCREENING EXAMS

| | Results | Date |
|---|---|---|
| Pap smear | | |
| Mammogram | | |
| Occult Blood | | |
| Bone Scan | | |
| CBC | | |
| Thyroid survey | | |
| Lipid profile | | |
| Serum hormone levels (FSH/LH) | | |
| Other | | |

## EDUCATION

1. Risks/ Benefits/ Contraindications
2. Evaluation of risk factors
3. Screening tests
4. Review types of HRT- benefits/ risks/ contraindications
5. Review preventive care practices- nutrition/ fitness/ skin exam