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 _____ History of oral contraceptives, # years used____
____ More than 2 alcohol drinks daily _____ Family history of ___ osteoporosis
____ Nulliparity (no pregnancies) _____ Heart disease
____ Thin, fair skinned _____ Breast cancer
____ Premature menopause (surgical or natural) age____
____ Sedentary lifestyle _____ Uterine/ovarian cancer
____ Calcium deficiency

PAST MEDICAL HISTORY

____ Gum disease _____ Cirrhosis of liver
____ Cushing’s disease _____ High blood pressure
____ Paralysis _____ Hyperparathyroidism
____ Diabetes _____ 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 _____ Change in sexual desire
____ Sleep disturbances _____ Pain with intercourse
____ Heart palpitations _____ Bleeding with intercourse
____ Weakness or fatigue _____ Leaking of urine
____ Anxiety or depression _____ Current history of vaginal infection
____ Mood swings _____ 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

<table>
<thead>
<tr>
<th>Results</th>
<th>Date</th>
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<tbody>
<tr>
<td>Pap smear</td>
<td>____________________</td>
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<tr>
<td>Mammogram</td>
<td>____________________</td>
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<tr>
<td>Occult Blood</td>
<td>____________________</td>
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<td>Bone Scan</td>
<td>____________________</td>
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<td>CBC</td>
<td>____________________</td>
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<td>Thyroid survey</td>
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<td>Lipid profile</td>
<td>____________________</td>
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<td>Serum hormone levels (FSH/LH)</td>
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<tr>
<td>Other</td>
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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