

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) _____ Periodontal 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	_____ Postmenopausal
_____ History of smoking # of years _____	_____ History of irregular menses (age 20-40)
_____ Constant dieting used _____	_____ History of oral contraceptives, # years
_____ 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 _____	_____ uterine/ovarian cancer
	_____ Sedentary lifestyle
	_____ 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

	<u>Results</u>	<u>Date</u>
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
