Menopause: Your Management Your Way …
Now and for the Rest of Your Life

Worksheet ©

1. Your age:

2. Do you have a uterus?   Uterus present   Uterus absent
   Do you have at least one ovary?   Ovary(ies) present   Ovaries absent
   Was your menopause premature?   After age 45   Before age 45
   Was your menopause natural or surgical? Natural   Surgical

3. Which are you?   Peri-menopausal   Post-menopausal
   At what age did you begin peri-menopause? _____
   At what age did you become post-menopausal? _____

4. What symptoms do you have?   Periods with a personality change
                                     Hot flashes
                                     Night sweats
                                     Insomnia
                                     Fatigue
                                     Forgetfulness
                                     Mood swings
                                     Irritability
                                      Depression
                                     Cravings for sweets, carbs, alcohol
                                     Breast pain
                                     Joint stiffness or joint pain
                                     Dry skin
                                     Hair loss on your scalp
                                     Hair growth in undesirable locations
                                     Vaginal dryness
                                     Urinary tract infections
                                     Urinary incontinence
                                     Weight gain
                                     Increased or decreased sex drive
                                     Acne
                                     Headaches

5. What are your risks for a heart attack?

Previous heart attack
Smoking
High bad LDL
Low good HDL
High triglycerides
Obesity
Truncal obesity
High blood pressure
Diabetes
Sedentary life style
Gum disease
High homocysteine
Depression
Family history

6. What are your risks for osteoporosis?

Race (White >Asian> Black)
Naturally blonde hair
Thin body habitus
Family history of osteoporosis
Premature menopause (before 40)
Tendency to fall
Sedentary lifestyle
Smoking
Diet high in caffeine
Excessive alcohol
Chronic excessive exercise
Anorexia or bulimia
Diabetes
Thyroid disease
Vitamin D deficiency
Lack of sun exposure
Meds for thyroid disease
Use of steroids
Meds: Immunosuppressants
        Blood thinners
        Anticonvulsants
        Valium
        Librium
        Ativan
        Lithium
        Tamoxifen (pre-menopause)

7. What are your risks for breast cancer? Previous breast cancer
Family history (maternal first degree)
Age _____
First full term pregnancy after age 30
Few pregnancies
First period before age 12
Menopause after age 55
Smoking
Sedentary lifestyle
Obesity
High fat diet
Benign breast disease
Regular alcohol consumption
Exposure to intense radiation
Dense breasts

8. What are your risks for uterine cancer? Age over 45
   (Ignore if you have no uterus)   Obesity
Excess estrogen without progesterone

9. What are your risks for ovarian cancer?   Genetics
Personal history of breast cancer
Age (post-menopause)
Obesity
First period before age12
No pregnancies
First pregnancy after age 30
Menopause after age 51
Infertility
Infertility drugs
Talcum powder use in genital area
High fat diet
Low fiber diet

10. What are your risks for Alzheimer's?   Age over 65
Genetics (positive family history)
Previous traumatic head injury
Lower educational level
High blood pressure
High cholesterol
Low levels of folate

11. What is your body type? Thin from head to toe
Pudgy from head to toe
Very solid & muscular
Fat accumulation in the torso
Fat accumulation in the hips/thighs
Underweight
Ideal weight
Overweight
Obese
Morbidly obese
Height _____
Weight _____
BMI _____

12. Describe your diet:

Fat	High	Med	Low
Meat	High	Med	Low
Sugar	High	Med	Low
Caffeine	High	Med	Low
Processed food	High	Med	Low
Fiber	High	Med	Low
Fruit	High	Med	Low
Veggies	High	Med	Low
Soy	High	Med	Low

13. Describe your lifestyle:

Exercise	Hours / week	Intensity	
Aerobic		High	Low
Resistance		High	Low
Balance/Core		High	Low
Flexibility/Yoga		High	Low

Alcohol: Number of drinks:_____Per day Per week
Smoking: Number of cigs: _____ Per day Per week

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14. What are your personal preferences?   Do nothing
     Short term management
     Long term management
     Short & long term management

15. What category(ies) do you prefer?   Diet & lifestyle
     Vitamins & minerals
     Botanicals & herbs
     Hormonal medications
          Natural
          Bioidentical
          Synthetic
     Non-hormonal medications
     Acupuncture
     Hypnosis

My Balancing Act

My History Questions # 1 - 3	**Positives**	**Negatives**

My Symptoms Question # 4	**Positives**	**Negatives**

My Risk Factors Questions # 5 - 10	**Positives**	**Negatives**

My Body & Lifestyle Questions # 11 – 13	**Positives**	**Negatives**

My Preferences Questions # 14 – 15	**Positives**	**Negatives**