Hormonal Health Questionnaire: Post-menopausal Women

Personal Information

* Indicates required question

1. Full Name *

2. Client ID *

3. How would you describe your overall energy level? *

Check all that apply.

- [ ] Excellent
- [ ] Good
- [ ] Low
- [ ] Very low

4. Have you experienced unexplained weight gain or loss? *

5. Have you noticed any of the following in last 3 months: *

Check all that apply.

- [ ] Hair thinning or hair loss
- [ ] Dry skin or brittle nails
- [ ] Cold hands & feet
- [ ] Constipation or sluggish digestion
- [ ] Fatigue especially in the morning
- [ ] Difficulty losing weight even with diet & exercise
- [ ] Feeling thirsty all the time
- [ ] Passing urine more often
- [ ] Need to eat more often to feel full
- [ ] Irritable, shaky, or lightheaded when you skip meals
- [ ] Increased belly fat
- [ ] Energy crashes in the afternoon
- [ ] Feel fatigue throughout the day
- [ ] Feel anxious, overwhelmed, or unable to cope with stress
- [ ] Trouble falling asleep or staying asleep
- [ ] Craving for salt or salty foods
- [ ] Muscle weakness

6. Menstruation History: When did you have your last period *

_____

7. Do you experience any of the following: *

Check all that apply.

- [ ] Night sweats
- [ ] Hot flushes
- [ ] Frequent UTIs
- [ ] Vaginal dryness
- [ ] Brain fog or poor concentration
- [ ] Difficulty to hold urine
- [ ] Leaking of urine while coughing/sneezing

8. Have these symptoms impacted your daily life or well-being? *

Mark only one oval.

- Yes- significantly
- Yes- somewhat
- No

9. Have you ever used hormone replacement therapy (HRT)?

Mark only one oval.

- Yes- Currently using
- Yes- in the past
- No
- Other: _____

10. If you used HRT, what was the main reason? (check all that apply) *

Check all that apply.

- [ ] Hot flushes/Night sweats
- [ ] Bone health
- [ ] Mood stabilization
- [ ] Vaginal dryness
- [ ] Doctor s recommendation
- [ ] Other- please explain
- [ ] Other: _____

11. Did you experience any side effects or concerns while on HRT?

Yes

Mark only one oval.

- ◯ Yes
- ◯ No

12. Are you currently taking any supplements or alternative therapies for hormone balance (e.g., soy, black cohosh, etc.)?

Mark only one oval.

- ◯ Yes
- ◯ No

13. Have you had a bone density test (DEXA scan) in last 1 year ? *

Mark only one oval.

- ◯ Yes- normal
- ◯ Yes- osteopenia
- ◯ Yes- osteoporosis
- ◯ No
- ◯ Not sure
- ◯ Other: _____

14. Do you engage in any of the following regularly? (check all that apply) *

Check all that apply.

- [ ] Weight-bearing exercise (walking, lifting)
- [ ] Balanced diet (calcium/vitamin D)
- [ ] Regular medical check-ups
- [ ] Stress management techniques (yoga, meditation, etc.)
- [ ] Other: _____

15. How well-informed do you feel about post-menopausal health? *

Mark only one oval.

- ◯ Very well-informed
- ◯ Somewhat informed
- ◯ Not informed at all

16. Would you like to see more education or resources for women in post-menopause? *

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Maybe