The Menopause Type Questionnaire™

Name: _____ **Date of Birth:** _____ **Date:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Place an "X" after a question if the answer is "yes" to that question, or any question in that group. If the answer is "no" leave the space blank.

SECTION A

1. Are you having hot flashes or night sweats, or both? ___
2. Are you feeling more depressed? Are you more withdrawn or isolated? Do you feel periods hopelessness? Do you feel apathetic? ___
3. Do you feel a loss of energy? Do you feel more fatigued? ___
4. Do you feel less receptive to sex? Do you feel less sensual? Do you feel that your sex drive is diminished? ___
5. Are you having increased vaginal pain, dryness or itching? ___
6. Are you having insomnia, difficulty falling to sleep or difficulty staying asleep? ___
7. Are you having trouble with your memory? Do you feel like you are having more trouble remembering names? Are you more forgetful? ___
8. Is your mood low, less upbeat, less positive or less outgoing? Are you having less "good moods' and times of joy? Do you find yourself caring less about things that used to matter to you? ___
9. Are you having trouble controlling your urine? Do you have to go more often? Do you spill urine when you cough or sneeze? ___
10. Do you feel as if your perception is weakening, that it takes you longer to notice things? Are you having trouble thinking of the right word when speaking or writing? Do you feel your mental skills are diminishing? ___

SECTION B

1. Are you having more aches and pain? Are you starting to get arthritis? ___
2. Are you having more spotting or break-through bleeding? Have you been told you have Dysfunctional Uterine Bleeding? ___
3. Do you seem to be getting more inflammations and swellings. ___
4. Are your allergies or asthma getting worse, or are you developing new allergies or asthma? ___
5. Do you feel like you are having more twitches and spasms? ___
6. Are you experiencing times of mental fogginess, or trouble thinking clearly? ___
7. Are you having more mood swings? ___
8. Do you feel more fatigued? Are you more tired in the morning? ___
9. Are you more irritable? Do you have more nervous tension? ___
10. Are you experiencing more anxiety? Do you feel more anxious? ___

SECTION C

1. Do you feel less motivated in general? Do you feel less assertive? ___
2. Is your libido lessened? Are you having less sexual fantasies or less desire? Are you less likely to become sexually aroused? Are you less pleased with sex? ___
3. Are you feeling less composed and in control? ___
4. Are you less energetic? ___
5. Are you anemic, or think you are anemic? ___
6. Are you feeling more irritable? ___
7. Do you have less muscle strength? Do you feel weaker? ___
8. Are you having more trouble with mental skills skill requiring logic and problem solving? Are you having trouble focusing and maintaining your attention? ___
9. Is your memory weakening? Are you having more trouble remembering things and events? ___
10. Do you feel more depressed? Is you mood low, less confident? Are you feeling frightened or afraid? ___

SECTION D

1. Are you noticing more wrinkles around your mouth and eyes? Do you have poor skin tone on you arms legs or hands? Has the skin lost its firmness or fullness? ___
2. Do you feel more depressed? . ___
3. Do you feel more fatigue in general? ___
4. Are you having more headaches? ___
5. Are you over 45 years old? ___

SECTION E

1. Do your breasts feel as if they are shrinking and sagging? ___
2. Are you experiencing more confusion? ___
3. Are you experiencing more morning fatigue? ___
4. Do you cry more easily, or more often? ___
5. Are your hands or feet colder? ___

SECTION F

1. Is your libido less than it used to be? ___
2. Is your pubic hair thinning? ___
3. Do you feel less motivation, less assertive, less confident? Have you lost your competitive edge? ___
4. Are you gaining more fat weight? Do you feel less lean? ___
5. Are you having more low back pain or hip pain? Do you feel more joint pain? Are you having more headaches? ___

SECTION G

1. Are you developing more facial Hair (hirsutism)? ___
2. Is your voice changing and becoming deeper or less feminine? ___
3. Are you having trouble tolerating sugars and carbohydrates? ___
4. Are you developing or having increased acne? ___
5. Do you feel more hostile, angry, agitated or aggressive? ___

Please list the name and the dose of any hormones you are taking, or have taken in the last three months.

Estrogen: _____

Progesterone: _____

Testosterone: _____

DHEA: _____

Other: _____

Please answer: Height: _____ Weight: _____ Waist: _____ inches Hip: _____ inches Weight at 20 years old: _____.

Interpretation of the Menopause Type Questionnaire™

Place totals from sections **A** through **G** of the Menopause Type Questionnaire in the "**SECTION**" column below. Multiply totals as indicated in columns **1** through **5**, then total each column. Follow Steps ***One*** through ***Seven*** to determine Your Menopause Type.

SECTION	1	2	3*	4	5
A =	A × 4 =		A × 2 =		
B =		B × 5 =	B × 2 =		
C =				C × 5 =	
D =	D × 4 =	D × 5 =	D × **6** =	D × 5 =	
E =	E × 4 =	E × 5 =	E × **6** =		
F =	F × 4 =			F × 5 =	
G =					G × 20 =
TOTALS	(E)	(P)	(D)	(T)	(A)

Step One: If columns 1, 2 & 3 are <u>each</u> less than 50, then place "A" in the "**GROUP BOX**" below and go to Step Five. If not, go to Step Two.

Step One	Column 1 Less than 50	Column 2 Less than 50	Column 3 Less than 50		

Step Two: If columns 1 & 2 are <u>both</u> less than Column 3, <u>or if both</u> Columns 1 & 2 are greater than 50 and equal to each other place "D" in the "**GROUP BOX**" below* and go to Step Five. If not, go to Step Three.

Step Two	Column 1 Less than Column 3	Column 2 Less than Column 3			

Step Three: If column 2 is less than column 1 place "**E**" in the "**GROUP BOX**" below* and go to Step Five. If not, go to Step Four.

Step Three		Column 2 Less than Column 1			

Step Four: If column 1 is less than column 2 place "**P**" in the "**GROUP BOX**" below* and go to Step Five.

Step Four	Column 1 Less than Column 2				

Step Five: If column 5 is greater than 50, place "H" in the "**T BOX**" below and go to Step Eight. If not, go to Step Six.

Step Five					Greater than 50

Step Six: If column 4 is greater than 50, and column 5 is less than 50 place "L" in the "**T BOX**" below and go to Step Eight. If not, go to Step Seven.

Step Six				Greater than 50	Less than 50

Step Seven: If columns 4 and 5 are both less than 50 place "N" in the "**T BOX**" below and go to Step Eight.

Step Seven				Less than 50	Less than 50

Step Eight: Match the two letters in the "Group Box" and the "T Box" to the chart below to determine Your Menopause Type based on ***subjective*** symptoms.
Learn more about subjective symptoms on pages 27-29 in "What's Your Menopause Type?"

GROUP BOX	T BOX
(A, D, P or E)	(H, L or N)

Menopause Type: (corresponding pages in "What's Your Menopause Type?")

AN = **Type 1**	(Page 83)	EN = **Type 4**	(Page 104)	PN = **Type 7**	(Page 127)	DN = **Type 10**	(Page 149)
AL = **Type 2**	(Page 87)	EL = **Type 5**	(Page 111)	PL = **Type 8**	(Page 133)	DL = **Type 11**	(Page 155)
AH = **Type 3**	(Page 96)	EH = **Type 6**	(Page 119)	PH = **Type 9**	(Page 139)	DH = **Type 12**	(Page 162)

It is also important to review objective data before making a final determination of your menopause type.
Objective data is also discussed on pages 27-29 in "What's Your Menopause Type?"

Notes: