



Dear patient,

in order to be able to help you with your request, I ask you to read carefully, answer the following questions, print it out and bring it with you.

**"Don't be afraid of the menopause!"**

Kind regards  
Dr. med. Harry Tschebiner

<b>MENOPAUSE-QUESTIONNAIRE</b>				
<b>Name:</b>				
<b>Date of birth:</b>				
<b>How old are you?</b>				
<b>When did you have your last menstrual bleeding (month/year)?</b>				
<b>Since when have you had complaints (month/year)?</b>				
<b>Which kind of symptoms do you have now, which you did not have 5 years ago?</b>				<b>Severity 1-10</b>
<b>Enter symptom severity before (A) and at dates after (B, C or D) start of treatment (improvement?)</b>				<b>A</b> <b>B</b> <b>C</b> <b>D</b>
1. Hot flushes, Sweats				
2. Sleeping disorders (falling asleep / waking up)				
3. Mood swings, Depression, Anxiety				
4. Restlessness, Irritability				
5. Heart palpitations				
6. Exhaustion (physically / mentally)				
7. Libido Disorder (Lack of sexual desire)				
8. Muscle- and Joint problems				
9. Dry vaginal mucosa				
10. Weight gain (kg) since ... months?				
<b>Date on A   B   C   D, depending, when you fill the column!</b>				