RMC | RÓZSAKERT MEDICAL CENTER

Dear Patient,

Please fill in the following questionnaire to help ensure the success of the complex menopause care program and to facilitate smooth data collection and risk assessment during visits.

Name:	
Date of birth:	

Do you suffer from any chronic disease (e.g. high blood pressure, diabetes, reflux, etc.)?	
yes	no
If yes, please list any medical conditions you have:	
Do you take medication regularly?	
yes	no
If yes, please list what medicines you are taking and at what dose:	
Do you know if you are sensitive to any drugs?	
yes	no
If yes, please list what you are allergic to:	

Please tell us what operations you have had and when they took place:	
Do you smoke?	
yes	no
Does any of your first-degree relatives have a history of thrombosis/embolism?	
yes	no
Are you aware of hereditary thrombosis in your family?	
yes	no
Please enter your height (in centimetres) and weight (in kg):	
cm	kg
Do you have a history of breast cancer, DCIS, LCIS, or chest radiotherapy (e.g. for Hodgkin's lymphoma)?	
yes	no

Are you aware of any genetic factors that makes you susceptible to breast cancer (e.g. carrying BRCA1 or BRCA2)?		
I am proven to carry it	I am proven not to carry it	do not know/has not been tested

Have you had a breast biopsy for a benign abnormality in the past?	
yes	no
If yes, how many times?	

If a breast biopsy has been conducted, has the histological examination ever confirmed atypia, hyperplasia?	
yes	no
Has any of your first-degree relatives had breast cancer	
yes	no
If you have a first-degree relative with breast cancer, how many first-degree relatives have had it?	
How old were you when you had your first period?	
Have you ever given birth to a child?	
yes	no
If yes, how old were you when you had your first child?	
When was your last cervical cancer screening and what were the results?	
When was the last mammography/breast ultrasound and what were the results?	
When was your last period?	
Do you have difficulty retaining urine?	
yes	no
(If you answered yes to the above question, please complete the attached urination diary. This is not necessary if the answer is no.)	

Do you suffer from any of the following? If yes, please tick the appropriate box.	
hot flushes	sweating/night sweats
vaginal dryness	change in sexual desire
irritability, mood instability	sleep disorders
Have you previously used menopausal hormone replacement therapy?	
yes	no
Are you currently using hormone replacement therapy?	
yes	no
If you are using herbal products to relieve menopausal symptoms, please list what you are using and in what amount:	

Please also fill in the quality of life questionnaire below:

Symptom	no	yes	How much you have been bothered by the problem? (1 – not at all bothered; 5-extremely bothered) 1	2	3	4	5
1.Vasomotor hot flushes							
night sweats							
sweating							
2. Psychological Being dissatisfied with my personal life?							

Feeling anxious or nervous?							
Experiencing poor memory?							
Accomplishing less than I used to?							
Feeling depressed, down or blue?							
Being impatient with other people?							
Feelings of wanting to be alone?							
3. Physical Flatulence (wind) or gas pains?							
Aching in muscles and joints?							
Feeling tired or worn out?							
Difficulty sleeping?							
Aches in back of neck or head?							
Decrease in physical strength?							
Decrease in stamina?							
Feeling a lack of energy?							
Drying skin?							
Weight gain?							
Increased facial hair?							
Changes in appearence, texture or tone of your skin?							
Feeling bloated?							
Low backache?							
Frequent urination?							
Involuntary urination when laughing or coughing?							
4. Sexual Change in your sexual desire?							
Vaginal dryness during intercourse?							
Avoiding intimacy?							

Please also complete the calcium intake questionnaire below:

Please provide answers about your eating habits in the previous 4 weeks when completing the questionnaire	**Unit (cup, portion, piece)**	**Calcium per day (mg)**	**Calcium per week (mg)**
1. Do you drink milk every day?	cup/day (1 cup = 2 dl)	236	1180
If you do not drink milk daily, do you drink milk every week?			236
2. Do you have yogurt, kefir, curdled milk every week?	portion/week (1 portion = 1 dl)		120
3. Do you eat sour cream every week?	portion/week (1 portion = 1 dl)		100

4. Do you eat cheese regularly every week?	portion/week (1 portion = 2 dkg)		132
5. How much bread and how many bakery products do you eat per day?	portion/day (1 portion = 2 slices)	34	170
6. How much pasta or rice do you eat per week?	portion/week (1 portion = 10 dkg)		20
7. Do you eat meat regularly every week? Chicken meat, beef.....	portion/week (1 portion = 10 dkg)		8
Pork.....	portion/week (1 portion = 10 dkg)		13
Cold cuts, baloney, saveloy, sausages.....	portion/week (1 portion = 10 dkg)		20
8. Do you eat oily fish (canned) every week?	portion/week (1 portion = 1 can)		270
9. How many vegetable dishes do you eat per week? creamed spinach, sorrel, beans	portion/week (1 portion = 30 dkg)		336
green peas, savoy cabbages, green beans?	portion/week (1 portion = 30 dkg)		150
10. How many potatoes do you eat per week?	portion/week (1 portion = 10 dkg)		8
11. How many eggs do you eat per week?	pieces/week		34
12. How many medium-sized apples or bananas do you eat per week?	pieces/week		apple: 6 banana: 110
13. Have you eaten any other fruits recently? (e.g. oranges, raspberries, strawberries)	portion/week (1 portion = 10 dkg)		45
14. Do you regularly eat oil seeds every week? poppy seeds, roasted pumpkin seeds.....	portion/week (1 portion = 5 dkg)		poppy seeds: 700 pumpkin seeds: 33
walnuts, almonds.....	portion/week (1 portion = 5 dkg)		49
sunflower seeds, raisins, peanuts, chestnuts.....	portion/week (1 portion = 5 dkg)		50