The Menopause-Specific Quality of Life Questionnaire

Name_____ **Today's date**_____

For each of the following items, indicate whether you have experienced the problems in the PAST MONTH. If you have, rate how much you have been bothered by the problem.

Not at all bothered - 0 1 2 3 4 5 6 - Extremely bothered

1.	Hot flushes	No	Yes	0	1	2	3	4	5	6
2.	Night sweats	No	Yes	0	1	2	3	4	5	6
3.	Sweating	No	Yes	0	1	2	3	4	5	6
4.	Being dissatisfied with my personal life	No	Yes	0	1	2	3	4	5	6
5.	Feeling anxious or nervous	No	Yes	0	1	2	3	4	5	6
6.	Experiencing poor memory	No	Yes	0	1	2	3	4	5	6
7.	Accomplishing less than I used to	No	Yes	0	1	2	3	4	5	6
8.	Feeling depressed, down or blue	No	Yes	0	1	2	3	4	5	6
9.	Being impatient with other people	No	Yes	0	1	2	3	4	5	6
10.	Feelings of wanting to be alone	No	Yes	0	1	2	3	4	5	6
11.	Flatulence (wind) or gas pains	No	Yes	0	1	2	3	4	5	6
12.	Aching in muscle & joints	No	Yes	0	1	2	3	4	5	6
13.	Feeling tired or worn out	No	Yes	0	1	2	3	4	5	6
14.	Difficulty sleeping	No	Yes	0	1	2	3	4	5	6
15.	Aches in back of neck or head	No	Yes	0	1	2	3	4	5	6
16.	Decrease in physical strength	No	Yes	0	1	2	3	4	5	6
17.	Decrease in stamina	No	Yes	0	1	2	3	4	5	6
18.	Feeling a lack of energy	No	Yes	0	1	2	3	4	5	6
19.	Drying skin	No	Yes	0	1	2	3	4	5	6
20.	Weight gain	No	Yes	0	1	2	3	4	5	6
21.	Increased facial hair	No	Yes	0	1	2	3	4	5	6
22.	Changes in appearance, texture or tone of your skin	No	Yes	0	1	2	3	4	5	6
23.	Feeling bloated	No	Yes	0	1	2	3	4	5	6
24.	Low backache	No	Yes	0	1	2	3	4	5	6
25.	Frequent urination	No	Yes	0	1	2	3	4	5	6
26.	Involuntary urination when laughing or coughing	No	Yes	0	1	2	3	4	5	6
27.	Change in your sexual desire	No	Yes	0	1	2	3	4	5	6
28.	Vaginal dryness during intercourse	No	Yes	0	1	2	3	4	5	6
29.	Avoiding intimacy	No	Yes	0	1	2	3	4	5	6

Thank you for completing this questionnaire.