The Menopause-Specific Quality of Life Questionnaire

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

		Not at all bothered									Extremely bothered
				0	1	2	3	4	5	6	
1.	HOT FLUSHES OR FLASHES	❑ 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

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		0	1	2	3	4	5	6		
12. ACHING IN MUSCLES AND 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	❑ Yes	❑ No	→	0	1	2	3	4	5	6
23. FEELING BLOATED	❑ No	❑ Yes	→	0	1	2	3	4	5	6

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	Not at all bothered		0	1	2	3	4	5	6	Extremely bothered
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	☐ Yes	☐ No	→	0	1	2	3	4	5	6
29. AVOIDING INTIMACY	☐ No	☐ Yes	→	0	1	2	3	4	5	6

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