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	
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	❑ 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	