Patient assessment

The following information should be obtained as it underpins the need for further investigation and treatment choices.

Symptoms, gynecological history and contraception
- Hot flushes and night sweats
- Sleep disturbance
- Vaginal dryness
- Sexual problems
- Urinary symptoms
- Other symptoms, such as problems with short-term memory and concentration, or muscle and joint discomfort
- Age at menarche
- Date of last menstrual period
- Frequency, heaviness and duration of periods
- History of benign or malignant gynecological conditions
- History of gynecological surgery
- Contraception

Personal history
- Smoking and alcohol consumption
- Diet/nutrition and physical activity
- Deep-vein thrombosis or pulmonary embolism
- Hypertension
- Diabetes
- Cancer
- Obstetric history
- Risk factors for osteoporosis
- Thyroid disease
- Migraine
- Mental health
- Cervical and breast cancer screening
- Medicines, alternative and complementary therapies, and supplements

Family history
- Breast, ovarian or bowel cancer in close family members
- Deep-vein thrombosis or pulmonary embolism
- Heart disease or stroke
- Dyslipidemia
- Dementia and cognitive disorders
- Osteoporosis

Patient preference
- What are the most important management endpoints?
- Are hormonal or non-hormonal options preferred?

Assessing menopause symptoms and needs as well as personal and family history will aid shared decision-making about any need for further investigation, or specialist referral and management.

Further information
National Institute for Health and Care Excellence. Menopause: diagnosis and management
https://www.nice.org.uk/guidance/ng23