The goals of a health evaluation of a woman around menopause are similar to those throughout her life span, tailored to her not only as an individual but also to the known physical and psychological consequences of menopause. Such an evaluation presents an opportunity to identify specific menopause-related issues and provide appropriate anticipatory guidance, plan preventive care, diagnose early disease, and determine the need for treatment, if any.

As women move through the menopause transition, regular health examinations are the standard of care. Although some experts have questioned the value of the periodic health examination, a recent systematic review concluded it was justified.

In general, the clinical evaluation includes the following:

- Detailed medical, psychological, and social history of the woman, including family history
- Complete physical examination, including vital signs, height and weight, as well as thyroid, breast, pelvic, and rectovaginal examinations
- Laboratory testing when indicated, such as fasting serum cholesterol (total, high-density lipoprotein cholesterol [HDL-C], and low-density lipoprotein cholesterol) [LDL-C], triglycerides, glucose, Papanicolaou (Pap) test, thyroid testing, urine screens, screens for sexually transmitted infections (STIs), and stool for occult blood
- Appropriate testing to evaluate problems (eg, abnormal uterine bleeding)
- Other age- and risk-appropriate screening tests (eg, bone density, mammogram, skin, colon cancer screening, glaucoma screening, and hearing test (see diagnostic and screening tests on page 189).

This discussion is general, so clinicians will want to consider the appropriate approach for each individual patient. Because this section of the textbook focuses on specific menopause-related issues, it does not include all the possible elements of a comprehensive physical examination.

History gathering

The comprehensive, nine-page Menopause Health Questionnaire developed by The North American Menopause Society (NAMS) can assist practitioners in gathering a menopause-focused history. This is available on the NAMS Web site (www.menopause.org/edumaterials/questionnaire.pdf).

Medical history. A complete medical history of a menopausal woman will include information from the following areas.

Symptom history. Ask detailed questions about symptoms that could be related to menopause and rate them according to frequency, severity, and duration. Although the 2005 State-of-the-Science Conference Statement on Management of Menopause-Related Symptoms from the National Institutes of Health definitively attributes only vasomotor symptoms, painful intercourse, and possibly sleep disturbance to menopause, women often experience many additional physical and psychological symptoms around menopause. Whether these concerns are related to menopause or aging, potential areas of discussion include hot flashes, night sweats, difficulty sleeping, vaginal dryness, dyspareunia, moodiness, anxiety, depression, urinary symptoms, sexual issues (desire, arousal, orgasm), hair and skin changes, weight gain, joint pain, and memory.

Numerous symptom inventories can be used to evaluate menopausal women. The most widely used is the 21-question Greene Climacteric Scale, which is easily administered and scored.

Gynecologic history. Review a woman's menstrual history, including age at menarche and description of menses since her premenopausal years. Note all gynecologic problems, including ovarian cysts, polycystic ovarian syndrome, fibroids, infertility, endometriosis, STIs, abnormal Pap smears, diethylstilbestrol exposure in pregnancy, and gynecologic surgery.

It is important to establish the date and results of the patient's last clinical breast and pelvic examinations as well as laboratory and radiologic examinations and screening tests, such as Pap smear, mammogram, and tests for cholesterol and bone density.

Obstetric history. Establish the number of pregnancies, full-term births, premature births, abortions, and living children; the woman's age at time of first birth; and significant complications during pregnancy or delivery.

History of serious illness. Exploring a woman's self-perceived health status provides a context to address her response and her own approach to menopause. Put special emphasis on cardiovascular disease (CVD), diabetes mellitus (DM), cancer, and osteoporosis, although any serious medical condition is relevant (see identification of modifiable health risk factors on page 184). Review her hospitalizations.

Surgical history. Get a full history of all the patient's surgeries.

Medication history. In addition to current medication use (prescription, nonprescription, complementary and alternative therapies) and allergies to any of them, ask about current and past hormone use (eg, hormonal contraceptives and menopausal hormone therapy [HT]). It is often revealing to ask specifically about prior strategies to deal with symptoms attributed to menopause. For all medications—especially those used for menopause-related symptoms—ask about duration of use, effectiveness, and reasons for stopping if they are no longer used.