

'Health Behaviors & Experiences in Menopause' Questionnaire

1. Are you a female?

- Yes
- No

If “No” is selected in QUESTION 1, please stop the survey and display the following verbiage:

“Thank you for your interest in this Pennington Biomedical study. To learn more about our studies, please visit www.pbrc.edu/healthierLA.”

2. Approximately how much do you weigh?

- lbs
- I don't know

3. Approximately how tall are you?

- feet inches
- I don't know

4. Please indicate your age:

- Under 18 years
- 18-39 years
- 40-44 years
- 45-49 years
- 50-54 years
- 55-59 years
- 60+ years
- I prefer to not answer

If “Under 18 years” is selected in QUESTION 4, please stop the survey and display the following verbiage:

“Thank you for your interest in this Pennington Biomedical study. We are seeking input from women 18 and older, but we sincerely appreciate your time and effort. To learn more about our studies, please visit www.pbrc.edu/healthierLA.”

5. At approximately what age did you have your first menstrual period?

- years old
- I don't know

6. Have you had a full or partial hysterectomy (“uterus removed”)?

- Yes
- No
- I don't know / I prefer to not answer

7. Have you had a bilateral oophorectomy (“both ovaries removed”)?

- Yes
- No
- I don't know / I prefer to not answer

8. Which stage of menopause are you currently in?

MENOPAUSE STAGE	DESCRIPTION	
Pre-Menopause	<i>"I do not have menopausal symptoms yet, and I continue to have regular or variable periods."</i>	<input type="radio"/>
Peri-menopause – Early Phase	<i>"I am currently experiencing menopausal symptoms. I have regular monthly periods, but the length or flow of each period varies."</i>	<input type="radio"/>
Peri-Menopause – Late Phase	<i>"I am experiencing menopausal symptoms and have not gone 12 months in a row without a period, but I sometimes have more than 60 days between periods."</i>	<input type="radio"/>
Post-Menopause – Symptomatic	<i>"I haven't had my period in over 12 months, but I continue to have menopausal symptoms."</i>	<input type="radio"/>
Post-Menopause – Asymptomatic	<i>"I haven't had my period in over 12 months, and I no longer have (or never had) menopausal symptoms."</i>	<input type="radio"/>

If "Pre-Menopause" is selected in QUESTION 8, display the following verbiage:

"Thank you for participating in our study. Your time and effort is appreciated as we strive to reduce menopausal symptoms and improve quality of life in middle-age women. The information you provided will help women who are currently transitioning through menopause, and we hope that you can benefit from our survey findings in the future."

If "Peri-Menopause – Early Phase" OR "Peri-Menopause – Late Phase" OR "Post-Menopause – Symptomatic" is selected in QUESTION 8, proceed to QUESTIONS 9-21:

9. Please rate your experience of symptoms which have sometimes been associated with menopause. Consider your experience with these symptoms over the last 1 month.

	NOT AT ALL	MILD	MODERATE	SEVERE
Hot flashes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insomnia (trouble sleeping)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tingling/prickling sensation (or pain) in extremities (arms and/or legs)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Muscle aches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart palpitations (racing heart, irregular beats)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nervousness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night sweats	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irritability (mood swings)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vaginal dryness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skin dryness or changes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hair loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of focus (easily physical or mental exhaustion, poor concentration)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Poor memory (forgetfulness)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Low sex drive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. Do your menopausal symptoms interfere with your normal daily activities?

- Always
- Sometimes
- Never
- I don't know / I prefer to not answer

11. Do you currently take (or have you taken) hormone replacement therapy (HRT) for your menopausal symptoms?

- Yes
- No
- I don't know / I prefer to not answer

If "No" is selected in QUESTION 11, proceed to QUESTION 11A:

11a. Why are you not using hormone replacement therapy (HRT)?

- I have never considered HRT
- I am not a suitable candidate for HRT (Examples: too far past menopause, cannot take estrogen, etc.)
- I prefer not to take hormones
- I find that other remedies help reduce my postmenopausal symptoms
- I don't know / I prefer to not answer

12. What other remedies have you ever used to combat your menopausal symptoms? Please check all that apply.

- Herbal (black cohosh, chasteberry, etc.)
- Mindfulness
- Changing your Diet
- Physical Activity / Exercise
- Meditation / Relaxation
- Breathing Exercises
- Chiropractic Care / Spinal Manipulations
- Sleep Aids
- Acupuncture
- Massage
- I haven't tried any other remedies

If "I haven't tried any other remedies" is selected in QUESTION 12, do not display QUESTION 12A. Please display only those remedies in QUESTION 12A that are checked in QUESTION 12:

12a. Please rate how effective these remedies were at reducing your menopausal symptoms.

	NOT AT ALL	SOMEWHAT	VERY
<i>Herbal (black cohosh, chasteberry, etc.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Mindfulness</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Changing your Diet</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Physical Activity / Exercise</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Meditation / Relaxation</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<i>Breathing Exercises</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Chiropractic Care / Spinal Manipulations</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Sleep Aids</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Acupuncture</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Massage</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13. Did diet or lifestyle changes help decrease your menopausal symptoms?

- Yes
- No
- I haven't tried
- I don't know / I prefer to not answer

14. How often do you exercise (or perform physical activity)?

- Never
- Rarely
- Occasionally
- At least 3 times per week
- Almost daily
- I don't know / I prefer to not answer

If "Never" is selected in QUESTION 14, do not display QUESTION 14A.

14a. Please rank those exercises or physical activities that you prefer to do.

	NOT AT ALL	SOMETIMES	VERY
<i>Walk</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Bike/Cycle</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Run/Jog</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Swim Laps</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Aqua Aerobics</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Resistance Training (weights, resistance bands, etc.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Exercise Class (gym aerobics)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Tai Chi</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Yoga</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Pilates</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- I prefer to not answer*

15. Do you perform any of the following holistic remedies (of the mind, body, spirit, and emotions) to help reduce your menopausal symptoms?

- Yes
- No
- I don't know / I prefer to not answer

If “No” is selected in QUESTION 15, do not display QUESTION 15A.

15a. Please rank those holistic remedies that you prefer to do.

	NOT AT ALL	SOMETIMES	VERY
Mindfulness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Meditation / Relaxation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breathing Exercises	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chiropractic Care / Spinal Manipulations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Acupuncture	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Massage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

16. If available to you, would you be interested in a structured lifestyle program to help minimize your menopausal symptoms? (Examples: diet information, group physical activity classes, mindfulness, breathing exercises, menopause education information)

- Yes
- No
- I don't know / I prefer to not answer

17. Please rate elements of a lifestyle program that would be most important to you.

	NOT IMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
Weight Loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weight Maintenance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Holistic Exercises (mind, body, spirit, and emotions) (Examples: meditation, mindfulness, breathing)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical Activity Sessions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Menopause Education Information (Examples: why are these changes happening? What can I do to manage my symptoms?)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yoga / Pilates	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18. Please note any elements of a lifestyle program that you believe are important but we did not mention. (OPTIONAL)

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ANSWER NOT REQUIRED FOR SURVEY COMPLETION

19. Would you like to participate in these types of activities *in a group setting* with other women like you?

- Yes
- No
- I don't know / I prefer to not answer

20. Do you feel that you were prepared and knowledgeable about menopause before it happened to you?

- Yes
- No
- I don't know / I prefer to not answer

21. Knowing what you know now about transitioning through menopause, what would you suggest to someone else going through the menopause transition? How would you suggest she improve her quality of life through this transition? (OPTIONAL)

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ANSWER NOT REQUIRED FOR SURVEY COMPLETION

If “Post-Menopause – Asymptomatic” is selected in QUESTION 8, proceed to QUESTIONS 9-21:

9. Please rate your experience of symptoms which have sometimes been associated with menopause. Please recall your past (typical) experience with these symptoms.

	NOT AT ALL	MILD	MODERATE	SEVERE
Hot flashes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insomnia (trouble sleeping)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tingling/prickling sensation (or pain) in extremities (arms and/or legs)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Muscle aches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart palpitations (racing heart, irregular beats)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nervousness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night sweats	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irritability (mood swings)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vaginal dryness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skin dryness or changes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hair loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of focus (easily physical or mental exhaustion, poor concentration)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor memory (forgetfulness)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Low sex drive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. Did your menopausal symptoms ever interfere with your normal daily activities?

- Always
- Sometimes
- Never
- I don't know / I prefer to not answer

11. Have you taken (currently or in the past) hormone replacement therapy (HRT) for your menopausal symptoms?

- Yes
- No
- I don't know / I prefer to not answer

If “No” is selected in QUESTION 12, proceed to QUESTION 12A:

11a. Why did you never use hormone replacement therapy (HRT)?

- I never considered HRT
- I was not a suitable candidate for HRT (Examples: too far past menopause, could not take estrogen, etc.)
- I preferred not to take hormones
- I found that other remedies helped reduce my postmenopausal symptoms
- I don't know / I prefer to not answer

12. What other remedies did you ever used to combat your menopausal symptoms? Please check all that apply.

- a. Herbal (black cohosh, chasteberry, etc.)
- b. Mindfulness
- c. Changing your Diet
- d. Physical Activity / Exercise
- e. Meditation / Relaxation
- f. Breathing Exercises
- g. Chiropractic Care / Spinal Manipulations
- h. Sleep Aids
- i. Acupuncture
- j. Massage
- k. I haven't tried any other remedies

If "I haven't tried any other remedies" is selected in QUESTION 13, do not display QUESTION 13A. Please display only those remedies in QUESTION 13A that are checked in QUESTION 13:

12a. Please rate how effective these remedies were at reducing your menopausal symptoms.

	NOT AT ALL	SOMEWHAT	VERY
<i>Herbal (black cohosh, chasteberry, etc.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Mindfulness</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Changing your Diet</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Physical Activity / Exercise</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Meditation / Relaxation</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Breathing Exercises</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Chiropractic Care / Spinal Manipulations</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Sleep Aids</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Acupuncture</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Massage</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13. Did diet or lifestyle changes help decrease your menopausal symptoms?

- Yes
- No
- I haven't tried
- I don't know / I prefer to not answer

14. How often did you exercise (or perform physical activity) when you had menopausal symptoms?

- a. Never
- b. Rarely
- c. Occasionally
- d. At least 3 times per week
- e. Almost daily
- f. I don't know / I prefer to not answer

If “Never” is selected in QUESTION 15, do not display QUESTION 15A.

14a. Please rank those exercises or physical activities that you preferred to do leading up to menopause.

	NOT AT ALL	SOMETIMES	VERY
Walk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bike/Cycle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Run/Jog	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Swim Laps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Aqua Aerobics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Resistance Training (weights, resistance bands, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise Class (gym aerobics)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tai Chi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yoga	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pilates	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- I prefer to not answer

15. Did you perform any of the following holistic remedies (of the mind, body, spirit, and emotions) to help reduce your menopausal symptoms?

- a. Yes
- b. No
- c. I don't know / I prefer to not answer

If “No” is selected in QUESTION 16, do not display QUESTION 16A.

15a. Please rank those holistic remedies that you preferred to do.

	NOT AT ALL	SOMETIMES	VERY
Mindfulness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Meditation / Relaxation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breathing Exercises	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chiropractic Care / Spinal Manipulations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Acupuncture	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Massage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

16. If available to you during your menopause transition, would you have been interested in a structured lifestyle program to help minimize your menopausal symptoms? (Examples: diet information, group physical activity classes, mindfulness, breathing exercises, menopause education information)

- Yes
- No
- I don't know / I prefer to not answer

17. Please rate elements of a lifestyle program that would have been most important to you.

	NOT IMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
Weight Loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weight Maintenance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Holistic Exercises (mind, body, spirit, and emotions) (Examples: meditation, mindfulness, breathing)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical Activity Sessions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Menopause Education Information (Examples: why are these changes happening? What can I do to manage my symptoms?)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yoga / Pilates	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18. Please note any elements of a lifestyle program that you believe are important but we did not mention. (OPTIONAL)

BLANK COMMENT BOX

ANSWER NOT REQUIRED FOR SURVEY COMPLETION

19. Would you have liked the opportunity to participate in these types of activities *in a group setting* with other women like you?

- Yes
- No
- I don't know / I prefer to not answer

20. Do you feel that you were prepared and knowledgeable about menopause before it happened to you?

- Yes
- No
- I don't know / I prefer to not answer

21. Knowing what you know now about transitioning through menopause, what would you suggest to someone else going through the menopause transition? How would you suggest she improve her quality of life through this transition? (OPTIONAL)

BLANK COMMENT BOX

ANSWER NOT REQUIRED FOR SURVEY COMPLETION