



My Menopause Diary

Keeping a diary...

It can help to keep an eye on your diet and exercise levels amongst other lifestyle choices, a simple recognised way to do this is to keep a diary. Whether it's a food, sleep, or a hot flush diary it can be really helpful to focus on certain things which could be affecting your menopause and overall health.

A useful checklist of various symptoms that can occur and a handy record with lifestyle pointers to refer to.

Psychological symptoms

Do you suffer from any of the following symptoms
Are the symptoms cyclical and do they accompany other symptoms
Do you currently take any medication or alternative remedies that help
Have you tried any form of alternative therapy and does it help, for example CBT
Have you looked at your diet, alcohol intake and exercise levels

Anxiety
Poor concentration
Anger
Low mood swings
Poor memory
Irritability
Panic attacks
Lack of confidence

Genitourinary Symptoms

Do you suffer from any of the following symptoms
Do you currently take any medication or alternative remedies that help
Do you do your pelvic floor exercises
Have you downloaded the Squeezy app

Vaginal irritation
Vaginal dryness
Vaginal soreness
Vaginal discharge/infections
Urinary frequency, leakage, urgency or recurrent UTI
Reduced sex drive / libido
Uncomfortable/painful sexual intercourse

Lifestyle Diet and Exercise

Do you regularly exercise every week
How many times
Do you do a variety of exercise including aerobic and pilates/yoga
If exercise doesn't float your boat, you really need to do some...have you tried HIIT...
we are talking 10 minutes a day
Do you eat a healthy, balanced diet...
Do you eat regular meals
Do you drink plenty of water
What is your weekly alcohol intake...come on be honest!
Do you smoke
Have you tried any alternative therapies like reflexology or CBT (cognitive behavioural therapy)

Do you take any alternative remedies or supplements
Note down any medication and alternatives you are on

Physical symptoms

Periods...that Menstrual Cycle

When was your last period
Are your cycles regular
Length of bleed
Have your periods changed recently, for example...length of cycle/heaviness/flow
Do you take any medication or alternative remedies which help
Have you stopped wearing white jeans...

Palpitations

Do you ever experience palpitations
How severe are they
How long do they last for
How often do they occur
Do they accompany other symptoms
Is there anything you eat or drink which brings them on
Are there any situations that bring them on...
Brad Pitt & George Clooney - or whoever floats your boat - excluded
Is there anything you do which can help to reduce their intensity and frequency

Hot Flashes / Night Sweats

How often do you experience them
How long do they last for
How intense are they from a scale of 1 to 10 (glow – dripping wet)
Do any foods or drinks you consume trigger them
Do any situations you find yourself in trigger them...(back to Brad & George)
Do you take any medication or alternative remedies which help
Does anything you do help reduce the intensity and frequency of them, for example exercise or CBT

Joint Pains

Do you experience aching joints
Which joints are affected
Is the pain cyclical or constant
Which forms of exercise help
Do you take medication or alternative remedies to help relieve the pain
Have you experienced any reduced fine motor skill ability...dropped much lately

Headaches

Are they cyclical
Do they accompany other symptoms
Do certain foods and drinks trigger them
How intense are they from a scale of 1 - 10 (muzzy - migraines)
Does anything you do relieve them, for example exercise or dietary intake
Do you take any medication or alternative remedies which help

Insomnia

Are your sleep patterns interrupted by other symptoms
Could you change your bedtime routine to help symptoms
Have you looked at your diet and exercise levels
Have you reduced any form of techy stimulation in your bedroom

Bloating & Weight Gain

Have you had a good look at your diet and exercise levels...

Hot Flush Diary

This diary can help you decide whether to have treatment for your hot flushes or whether there are things you can do to manage them through lifestyle choices.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Number of hot flushes in the day:							
Number of night sweats:							
How long did they last today? (Tick all that apply)	<input type="checkbox"/> a few seconds <input type="checkbox"/> a few minutes <input type="checkbox"/> more than 10 mins	<input type="checkbox"/> a few seconds <input type="checkbox"/> a few minutes <input type="checkbox"/> more than 10 mins	<input type="checkbox"/> a few seconds <input type="checkbox"/> a few minutes <input type="checkbox"/> more than 10 mins	<input type="checkbox"/> a few seconds <input type="checkbox"/> a few minutes <input type="checkbox"/> more than 10 mins	<input type="checkbox"/> a few seconds <input type="checkbox"/> a few minutes <input type="checkbox"/> more than 10 mins	<input type="checkbox"/> a few seconds <input type="checkbox"/> a few minutes <input type="checkbox"/> more than 10 mins	<input type="checkbox"/> a few seconds <input type="checkbox"/> a few minutes <input type="checkbox"/> more than 10 mins
How did they affect you today? (Tick all that apply)	<input type="checkbox"/> a bit hot <input type="checkbox"/> quite hot & sweaty <input type="checkbox"/> very hot & sweaty	<input type="checkbox"/> a bit hot <input type="checkbox"/> quite hot & sweaty <input type="checkbox"/> very hot & sweaty	<input type="checkbox"/> a bit hot <input type="checkbox"/> quite hot & sweaty <input type="checkbox"/> very hot & sweaty	<input type="checkbox"/> a bit hot <input type="checkbox"/> quite hot & sweaty <input type="checkbox"/> very hot & sweaty	<input type="checkbox"/> a bit hot <input type="checkbox"/> quite hot & sweaty <input type="checkbox"/> very hot & sweaty	<input type="checkbox"/> a bit hot <input type="checkbox"/> quite hot & sweaty <input type="checkbox"/> very hot & sweaty	<input type="checkbox"/> a bit hot <input type="checkbox"/> quite hot & sweaty <input type="checkbox"/> very hot & sweaty
What do you think might have triggered your hot flushes today? (Tick all that apply)	<input type="checkbox"/> caffeine <input type="checkbox"/> alcohol <input type="checkbox"/> spicy food <input type="checkbox"/> hot drinks <input type="checkbox"/> stressful situation <input type="checkbox"/> change in temp. <input type="checkbox"/> smoking other _____	<input type="checkbox"/> caffeine <input type="checkbox"/> alcohol <input type="checkbox"/> spicy food <input type="checkbox"/> hot drinks <input type="checkbox"/> stressful situation <input type="checkbox"/> change in temp. <input type="checkbox"/> smoking other _____	<input type="checkbox"/> caffeine <input type="checkbox"/> alcohol <input type="checkbox"/> spicy food <input type="checkbox"/> hot drinks <input type="checkbox"/> stressful situation <input type="checkbox"/> change in temp. <input type="checkbox"/> smoking other _____	<input type="checkbox"/> caffeine <input type="checkbox"/> alcohol <input type="checkbox"/> spicy food <input type="checkbox"/> hot drinks <input type="checkbox"/> stressful situation <input type="checkbox"/> change in temp. <input type="checkbox"/> smoking other _____	<input type="checkbox"/> caffeine <input type="checkbox"/> alcohol <input type="checkbox"/> spicy food <input type="checkbox"/> hot drinks <input type="checkbox"/> stressful situation <input type="checkbox"/> change in temp. <input type="checkbox"/> smoking other _____	<input type="checkbox"/> caffeine <input type="checkbox"/> alcohol <input type="checkbox"/> spicy food <input type="checkbox"/> hot drinks <input type="checkbox"/> stressful situation <input type="checkbox"/> change in temp. <input type="checkbox"/> smoking other _____	<input type="checkbox"/> caffeine <input type="checkbox"/> alcohol <input type="checkbox"/> spicy food <input type="checkbox"/> hot drinks <input type="checkbox"/> stressful situation <input type="checkbox"/> change in temp. <input type="checkbox"/> smoking other _____

Sleep Diary

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
What time did you wake up?							
What time did you go to bed?							
Total time in bed?							
How long did it take you to fall asleep?							
How many times did you wake up with hot flushes?							
How long were you awake during the night?							
Total sleep time - how long did you sleep altogether?							

Food Diary

Use this diary to record what you have to eat and drink every day. Focus on counting the nutrients rather than the calories. The aim: a healthy, nutritious, balanced diet.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast							
Mid Morning							
Lunch							
Mid Afternoon							
Evening Meal							
Supper							

Bladder Diary

This is a basic bladder diary. If you have significant problems in this area please contact your GP for referral.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Record drinks taken over the day	am:	am:	am:	am:	am:	am:	am:
	pm:	pm:	pm:	pm:	pm:	pm:	pm:
Trips to the bathroom	am:	am:	am:	am:	am:	am:	am:
	pm:	pm:	pm:	pm:	pm:	pm:	pm:
Accidental leaks?	am:	am:	am:	am:	am:	am:	am:
	pm:	pm:	pm:	pm:	pm:	pm:	pm:

Essential Signposting:

The British Menopause Society: www.thebms.org.uk

The Daisy Network: www.daisynetwork.org

The Eve Appeal: www.eveappeal.org.uk

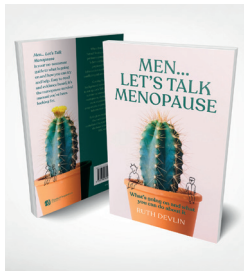
Let's Talk Menopause: www.letstalkmenopause.co.uk

Menopause Matters: www.menopausematters.co.uk

The Nice Guidelines: www.nice.org.uk/guidance/NG23

The Squeezy App: www.squeezyapp.com

Womens Health Concern: www.womens-health-concern.org



Men . . . Let's Talk Menopause *by Ruth Devlin*

*An easy to read, no nonsense, concise, comprehensive guide -
the Menopause survival manual you've been looking for!
Available from the usual outlets...Waterstones...Amazon...*



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