

MENOPAUSE SOCIETY PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. Which of the following is NOT a STRAW+10 phase?**
 - A. Reproductive
 - B. Menopausal Transition
 - C. Postmenopause
 - D. Luteal phase

- 2. HT in POI is recommended until the average age of menopause.**
 - A. The average age of menopause
 - B. Age 50
 - C. Age 60
 - D. For life

- 3. What is the age threshold for routine DXA screening in postmenopausal women, according to the North American Menopause Society?**
 - A. 50 years
 - B. 60 years
 - C. 65 years or older
 - D. 70 years

- 4. Which class of drugs is commonly used to treat osteoporosis?**
 - A. Bisphosphonates.
 - B. ACE inhibitors.
 - C. Thiazolidinediones.
 - D. Statins.

- 5. What symptoms are commonly associated with LOOP events during perimenopause?**
 - A. Regular bleeding with steady vasomotor symptoms
 - B. Heavy bleeding without vasomotor symptoms
 - C. Irregular bleeding and vasomotor symptoms
 - D. No bleeding and no symptoms

- 6. What is the recommended method for assessing central adiposity in cardiovascular risk assessment?**
- A. Body mass index
 - B. Hip circumference
 - C. Waist-to-hip ratio
 - D. Waist circumference
- 7. Frailty risk in midlife increases with aging and deficiency of which hormone?**
- A. Estrogen.
 - B. Testosterone.
 - C. Progesterone.
 - D. Cortisol.
- 8. What is the role of pelvic floor physical therapy in managing sexual dysfunction in menopause?**
- A. It worsens sexual function
 - B. It has no effect
 - C. It can improve sexual function and dyspareunia
 - D. It only helps urinary symptoms
- 9. Which of the following is an absolute contraindication to hormone therapy?**
- A. Undiagnosed vaginal bleeding
 - B. Osteoporosis
 - C. Hypertension
 - D. Hyperlipidemia
- 10. Which drug is an anabolic agent used in osteoporosis management?**
- A. Teriparatide
 - B. Alendronate
 - C. Denosumab
 - D. Raloxifene

Answers

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1. D
2. A
3. C
4. A
5. C
6. D
7. A
8. C
9. A
10. A

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Explanations

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1. Which of the following is NOT a STRAW+10 phase?

- A. Reproductive
- B. Menopausal Transition
- C. Postmenopause
- D. Luteal phase**

STRAW+10 describes stages of reproductive aging based on how ovarian function and menstrual cycles change over time. The main categories are Reproductive (regular cycles with preserved ovarian function), Menopausal Transition (perimenopause with increasing cycle variability and hormonal shifts), and Postmenopause (after menopause with low estrogen). The luteal phase, however, is a specific part of the menstrual cycle that occurs after ovulation and is ruled by progesterone, lasting about two weeks. It's a normal cycle phase, not a long-term aging stage. Because STRAW+10 is about aging and transitions in ovarian function rather than the routine cycle phases, the luteal phase isn't a STRAW+10 phase.

2. HT in POI is recommended until the average age of menopause.

- A. The average age of menopause**
- B. Age 50
- C. Age 60
- D. For life

In primary ovarian insufficiency, estrogen replacement is used to protect bones, heart health, and quality of life while the woman would have been naturally menopausal. The duration of therapy is therefore aligned with the time until the age at which menopause would normally occur. That point is the average age of natural menopause, which is about 50–51 years. So continuing hormone therapy until that average age makes sense: it covers the years of low estrogen and then can be reassessed as menopause would begin in most women around that time. Choosing a fixed age like 60 would extend therapy longer than typical need and may unnecessarily increase long-term risks. Taking it for life ignores the natural transition that happens around menopause. While age 50 is close to the average, stating it as the exact end point ignores the population-wide variation around the average. The phrasing “the average age of menopause” best captures the intended endpoint for therapy duration in POI.

3. What is the age threshold for routine DXA screening in postmenopausal women, according to the North American Menopause Society?

- A. 50 years
- B. 60 years
- C. 65 years or older**
- D. 70 years

Routine DXA screening for osteoporosis in postmenopausal women begins at age 65. The guideline allows for earlier, selective screening in women aged 50–64 if there are additional fracture risk factors such as a prior fragility fracture, long-term glucocorticoid use, low BMI, smoking, or a family history of hip fracture. This approach aims to identify those at higher risk while avoiding routine screening in lower-risk younger postmenopausal women. Ages 50 or 60 fall below the routine threshold, while 70 would be screened routinely because it is above 65.

4. Which class of drugs is commonly used to treat osteoporosis?

- A. Bisphosphonates.
- B. ACE inhibitors.
- C. Thiazolidinediones.
- D. Statins.

Treating osteoporosis centers on drugs that slow bone loss by inhibiting bone resorption. Bisphosphonates are the most commonly used and typically first-line therapy. They attach to bone and suppress osteoclast activity, reducing bone turnover and helping to increase or stabilize bone mineral density, which lowers the risk of fractures. Examples include alendronate, risedronate, ibandronate, and zoledronic acid, given orally on a weekly/monthly schedule or by yearly IV infusion. Other drug classes listed serve different roles. ACE inhibitors treat high blood pressure and heart failure, not osteoporosis. Thiazolidinediones are diabetes medications that can actually worsen bone density and fracture risk. Statins lower cholesterol and have unclear or limited evidence for a role in treating osteoporosis, so they are not standard osteoporosis therapies.

5. What symptoms are commonly associated with LOOP events during perimenopause?

- A. Regular bleeding with steady vasomotor symptoms
- B. Heavy bleeding without vasomotor symptoms
- C. Irregular bleeding and vasomotor symptoms
- D. No bleeding and no symptoms

During perimenopause, the ovaries become erratic and estrogen levels fluctuate, so ovulatory cycles become unpredictable and the endometrium sheds irregularly. This leads to irregular bleeding in both timing and flow. At the same time, instability in the hypothalamic–pituitary–ovarian axis and estrogen withdrawal produce vasomotor symptoms such as hot flashes and night sweats. The combination of irregular bleeding with vasomotor symptoms best reflects LOOP events in this phase, because it ties together the endometrial instability with the central temperature-regulation changes typical of this transition. Regular bleeding with steady vasomotor symptoms suggests more stable cycling, heavy bleeding without vasomotor symptoms is less typical for the common perimenopausal pattern, and no bleeding with no symptoms points away from the perimenopausal experience.

6. What is the recommended method for assessing central adiposity in cardiovascular risk assessment?

- A. Body mass index
- B. Hip circumference
- C. Waist-to-hip ratio
- D. Waist circumference

Central adiposity is best assessed for cardiovascular risk by measuring waist circumference because it directly estimates abdominal fat, especially visceral fat, which is strongly linked to metabolic disturbances that drive cardiovascular disease. This measure is simple, reproducible, and has consistently shown independent associations with cardiovascular events beyond overall obesity. While body mass index reflects total body weight relative to height, it misses how fat is distributed. Hip circumference by itself doesn't capture central fat. Waist-to-hip ratio adds distribution information but introduces more measurement variability and is not consistently superior to waist circumference alone in predicting risk. For these reasons, waist circumference is the recommended method.

7. Frailty risk in midlife increases with aging and deficiency of which hormone?

- A. Estrogen.**
- B. Testosterone.
- C. Progesterone.
- D. Cortisol.

Estrogen deficiency during the menopausal transition is a strong driver of frailty risk in midlife because estrogen helps protect both bone and muscle health and modulates metabolism and inflammation. When estrogen declines after menopause, bone resorption increases, leading to osteoporosis and higher fracture risk. At the same time, loss of estrogen contributes to decreases in muscle mass and strength (sarcopenia), reduced physical endurance, and changes in fat distribution, all of which undermine mobility and resilience. The overall effect is a higher likelihood of exhibiting frailty features such as weakness, slow gait, and reduced activity. While other hormones can influence aspects of frailty, the midlife drop in estrogen most directly ties to the frailty risk seen in aging women.

8. What is the role of pelvic floor physical therapy in managing sexual dysfunction in menopause?

- A. It worsens sexual function
- B. It has no effect
- C. It can improve sexual function and dyspareunia**
- D. It only helps urinary symptoms

Pelvic floor physical therapy helps by addressing the muscles and tissues that support the vagina and pelvis, which are central to comfortable and satisfying sexual activity. In menopause, estrogen loss leads to vaginal thinning and dryness that can cause pain with intercourse (dyspareunia), and the pelvic floor muscles may become tense or poorly coordinated for some women. PFPT uses individualized techniques such as relaxation and breathing strategies, biofeedback to normalize muscle activation, pelvic floor exercises tailored to restore balance of strength and flexibility, and manual or dilator therapy to ease penetration and reduce pain. By improving tissue health, increasing blood flow, and retraining pelvic floor function, PFPT can lessen pain during sex and improve overall sexual function. It is not limited to urinary symptoms; addressing sexual pain is a key benefit, and PFPT can be part of a broader management plan that may include lubricants, moisturizers, or vaginal estrogen as appropriate.

9. Which of the following is an absolute contraindication to hormone therapy?

- A. Undiagnosed vaginal bleeding**
- B. Osteoporosis
- C. Hypertension
- D. Hyperlipidemia

The main concept is that starting estrogen-containing hormone therapy requires ruling out underlying pathology that could be worsened by estrogen. Undiagnosed vaginal bleeding is an absolute contraindication because estrogen stimulates endometrial growth. If there's an unknown lesion such as endometrial hyperplasia or cancer, giving estrogen could promote progression or obscure the diagnosis, delaying proper treatment. This is why starting therapy isn't appropriate until the bleeding is investigated and ruled out as benign or managed appropriately. Osteoporosis, hypertension, and hyperlipidemia are not absolute barriers to hormone therapy. HT can be chosen or adjusted with these conditions in mind, such as using appropriate routes (e.g., transdermal) or ensuring conditions are controlled and monitored, rather than withholding therapy outright.

10. Which drug is an anabolic agent used in osteoporosis management?

A. Teriparatide

B. Alendronate

C. Denosumab

D. Raloxifene

Anabolic therapy for osteoporosis aims to build new bone by stimulating osteoblast activity. Teriparatide is a recombinant parathyroid hormone fragment given as daily injections; when exposure is intermittent, it preferentially promotes bone formation rather than bone resorption. This leads to increases in bone mineral density and a reduction in fracture risk, especially in individuals at high fracture risk or those who have not benefited from antiresorptives or have glucocorticoid-induced osteoporosis. In contrast, the other agents are antiresorptives: alendronate inhibits osteoclast-mediated bone breakdown, denosumab blocks RANKL to reduce resorption, and raloxifene—a selective estrogen receptor modulator—also acts mainly to decrease bone resorption and does not provide the same anabolic bone-building effect.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://menopausesociety.examzify.com>

We wish you the very best on your exam journey. You've got this!

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