CAPITAL WOMEN'S CARE

Working Together for Women's Health

Menopause is a normal event in a woman's life and is marked by the end of menstrual periods. Usually during the 40s, a gradual process leading to menopause begins. This is called the menopause transition or perimenopause. Changes in the pattern of menstrual periods are very common during this stage. Sometimes a woman can have other symptoms too, and these symptoms may extend beyond menopause. Even if a woman has no symptoms, it's important for her to understand the effects of menopause on her health.

This questionnaire is intended to help you inform your healthcare provider about your menopause experience and your general health. Working together, you can develop a plan to support your health, not only now but also in years to come. If you feel uncomfortable answering any of the questions on this form, you may wait and discuss them with your healthcare provider.

SECTION 1- TODAY'S OFFICE VISIT **Date**:_____

Name:_____ Date of birth: _____

Why are you here today?

_____

_____

What are your main concerns or questions you would like to have answered during your visit?

_____

_____

_____

Who referred you?

_____

SECTION 2- HEIGHT & WEIGHT INFORMATION

What is your maximum remembered height? _____ How old were you then? _____

What is your maximum remembered weight? _____ How old were you then? _____

What is your lowest remembered weight as an adult? _____ How old were you then? _____

SECTION 3- MEDICAL HISTORY

Please check if you have had problems with:

[ ] Migraine	[ ] Colitis	[ ] Diabetes	[ ] Sleeping
[ ] Blood Pressure	[ ] Diarrhea	[ ] Thyroid	[ ] Dizziness
[ ] Stroke	[ ] Constipation	[ ] Asthma	[ ] Mood swings
[ ] Cholesterol	[ ] Bloody or black stool	[ ] Arthritis	[ ] Suicidal thoughts
[ ] Heart Attack	[ ] Hepatitis	[ ] Muscle or joint pain	[ ] Teeth or gums
[ ] Chest pain	[ ] Liver	[ ] Back pain	[ ] Hair loss/growth
[ ] Blood clots	[ ] Gallbladder	[ ] Seizures	[ ] Skin
[ ] Varicose veins	[ ] Incontinence (urine or stool)	[ ] Eyesight	[ ] Frequent falling
[ ] Easy bruising	[ ] Breasts	[ ] Macular degeneration	[ ] Losing height
[ ] Anemia	[ ] Endometriosis	[ ] Cataracts	[ ] Broken bones
[ ] Indigestion	[ ] Fibroids	[ ] Depression	[ ] Weight loss or gain
[ ] Nausea or vomiting	[ ] Infertility	[ ] Anxiety	
[ ] Cancer	[ ] Stress	[ ] Fatigue	

Other health problems (describe): _____

_____

_____

SECTION 4- MAJOR ILLNESS & INJURY HISTORY

Date	List dates of all operations, hospitalizations, psychological therapy, major injuries, and illnessed (excluding pregnancy)

SECTION 5- GYNECOLOGIC HISTORY

How would you describe your current menstrual status?

[ ] Premenopause (before menopause; having regular periods)
[ ] Perimenopause/menopause transition (changes in periods, but have not gone 12 months in a row without a period)
[ ] Postmenopause (after menopause)

Was your menopause:
[ ] Spontaneous ("natural")
[ ] Surgical (removal of both ovaries)
[ ] Due to chemotherapy or radiation therapy; reason for therapy: _____
[ ] Other (explain): _____

Age at first menstrual period: _____

Are your periods (or were your periods) usually regular? [ ] Yes [ ] No

If not still having periods, what was your age when you had your last period? _____

If still having periods, how often do they occur? _____

How many days does your period last? _____

Are your periods painful? [ ] Yes [ ] No

If yes, how painful? [ ] Mild [ ] Moderate [ ] Severe

Do you have spotting or bleeding between periods? [ ] Yes [ ] No

Has your period recently become very heavy? [ ] Yes [ ] No

Do you think you have a problem with your period? [ ] Yes [ ] No
If yes, explain: _____

_____

Do you have any problems with PMS? (PMS is having mood swings, bloating, headaches, etc. prior to your period) [ ] Yes [ ] No

What is the date and results (if known) of your last test regarding:

Pap smear:_____	Any abnormal Pap tests?	[ ] Yes [ ] No	If yes, when? _____
Mammogram:_____	Any breast biopsies?	[ ] Yes [ ] No	If yes, when? _____
Thyroid: _____	Any abnormal thyroid test?	[ ] Yes [ ] No	If yes, when? _____

Cholesterol test: _____Colonoscopy: _____ Cologard: _____

Blood sugar test: _____ Genetic Cancer Screening test (ie BRCA 1&2): _____

Bone density test: _____

SECTION 6: OBSTETRICAL HISTORY

Please indicate the method of birth control, if any, that you are currently using: _____

How many times have you been pregnant? _____

How many children do you have? _____ How many were adopted? _____

How old were you when your first child was born? _____

How old were you when your last child was born? _____

Please provide the number of your:

Full term births:	Premature births:	Miscarriages:	Abortions:	Living children:

Any complications during pregnancy, delivery, or postpartum? [ ] Yes [ ] No

If yes, please describe: _____

_____

SECTION 7: SEXUAL HISTORY

Are you currently sexually active? [ ] Yes [ ] No

If yes, are you currently having sex with: [ ] A man/men [ ] A woman/women [ ] Both men & women

How long have you been with your current sex partner? _____

Are you in a committed, mutually monogamous relationship? [ ] Yes [ ] No

Do you have concerns about your sex life? [ ] Yes [ ] No

Do you have a loss of interest in sexual activities (libido, desire)? [ ] Yes [ ] No

Do you have a loss of arousal (tingling in the genitals or breast; vaginal moisture,warmth)? [ ] Yes [ ] No

Do you have a loss of response (weaker or absent orgasm)? [ ] Yes [ ] No

Do you have any pain with intercourse (vaginal penetration)? [ ] Yes [ ] No

If yes, how long ago did the pain start? _____

Please describe the pain: [ ] Pain with penetration [ ] Pain inside [ ] Feels dry

SECTION 8: ALLERGY INFORMATION

Are you allergic to any medications? [ ] Yes [ ] No [ ] Don't know....If yes, please indicate which one(s)

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Do you have any other allergies? [ ] Yes [ ] No [ ] Don't know....If yes, please indicate which one(s)

To what? _____Reaction: _____

To what? _____Reaction: _____

To what? _____Reaction: _____

SECTION 9: MEDICATION HISTORY

Are you currently using hormone therapy for menopause? [ ] Yes [ ] No

If yes, for what reasons? _____

_____

_____

Please indicate the medications and supplements (such as vitamins, calcium, herbs, soy) you are currently using. Include prescription drugs and those purchased without prescription. Also include all hormone therapy you have used in the past (examples include contraceptives, thyroid hormones, and hormone therapy for menopause).

Medication/Supplement	Dose	Frequency	Date Started	Date Stopped	Reason for Stopping

SECTION 10: FAMILY HISTORY

Please list family member (ie, mother, father, sister, brother, grandparent, aunt, uncle) who currently has or once had the following:

High blood pressure:	Colorectal cancer:
Heart attack (indicate age):	Ovarian cancer:
Stroke (indicate age):	Other cancer:
Blood problems:	Depression:
Blood clots:	Other emotional problems:
Bleeding tendency:	Alzheimer's disease:
Glaucoma:	Alcoholism:
Osteoporosis:	Drug abuse:
Hip fracture:	
Diabetes:	
Breast cancer (indicate age):	

Is there anything about your family's health history that concerns you, or that you would like to discuss? [ ] Yes [ ] No If yes, what? _____

SECTION 11: PERSONAL HABITS

Do you consider your health to be: [ ] Excellent [ ]Good [ ] Fair [ ] Poor

Exercise

How often do you exercise? [ ] Almost daily [ ] At least 3xweek [ ] Occasionally [ ] Rarely [ ] Never

If you exercise, what do you do?

_____

For how long and how often?

_____

Diet

How many meals do you consume each day?

_____

Do you try to eat a special diet? [ ] Low-fat [ ] Low carbohydrate [ ] High protein [ ] Vegetarian

What dairy products do you consume each day?

[ ] Milk How much? _____ [ ] Yogurt How much? _____

[ ] Cheese How much? _____ [ ] Other _____

Are you lactose intolerant (diarrhea or gastrointestinal upset after dairy products)? [ ] Yes [ ] No

How many servings of fruits do you consume each day?

_____

How many servings of vegetables do you consume each day?

_____

How many servings of soy foods do you consume each week?

_____

How many servings of fish do you consume each week?

_____

Tobacco use

Do you currently smoke cigarettes? [ ] Yes [ ] No

If yes, how many per day? _____ When did you start? _____

How do you feel about quitting smoking? _____

If you do not currently smoke cigarettes, have you ever smoked? [ ] Yes [ ] No

If yes, when did you start? _____How many per day? _____When did you stop? _____

Do you use any other type of tobacco? [ ] Yes [ ] No If yes, what? _____

Caffeine use

Do you consume drinks with caffeine (coffee, tea, soda drinks)? [ ] Yes [ ] No

If yes, how many drinks each day? _____

Alcohol and drug use

Do you drink alcohol? [ ] Yes [ ] No

If yes, how many drinks do you have each week? _____

Do you ever have a drink in the morning to get you going? [ ] Yes [ ] No

Have you ever tried to cut down on your drinking? [ ] Yes [ ] No

Have you ever felt guilty about the amount you dink? [ ] Yes [ ] No

Have you ever been an alcoholic? [ ] Yes [ ] No

Do you use illegal drugs? [ ] Yes [ ] No

Abuse

Within the last year, have you been hit, slapped, kicked, or physically hurt by someone? [ ] Yes [ ] No

Within the last year, has anyone ever forced you to have sexual activities? [ ] Yes [ ] No

Do you feel you are verbally or emotionally abused by someone? [ ] Yes [ ] No

Have you had counseling for these issues? [ ] Yes [ ] No

Stress management

What are the current major stressors or life changes in your life? _____

_____

_____

Any major changes in the family health during the past year? [ ] Yes [ ] No

If yes, explain: _____

_____

_____

How do you handle stress? [ ] Very well [ ] Moderately well [ ] Poorly

What do you do to relax?_____

_____

SECTION 12: SYMPTOMS

Please indicate how bothered you are now and in the past few weeks by any of the following:

	Not at all	A little bit	Quite a bit	Extremely
I have hot flashes	[ ]	[ ]	[ ]	[ ]
I have night sweats	[ ]	[ ]	[ ]	[ ]
I have difficultly getting to sleep	[ ]	[ ]	[ ]	[ ]
I have difficultly staying asleep	[ ]	[ ]	[ ]	[ ]
I get heart palpitations or a fluttering sensation in my chest or stomach	[ ]	[ ]	[ ]	[ ]
I feel like my skin is crawling or itching	[ ]	[ ]	[ ]	[ ]
I feel more tired that usual	[ ]	[ ]	[ ]	[ ]
I have difficulty concentrating	[ ]	[ ]	[ ]	[ ]
My memory is poor	[ ]	[ ]	[ ]	[ ]
I am more irritable than usual	[ ]	[ ]	[ ]	[ ]
I feel more anxious than usual	[ ]	[ ]	[ ]	[ ]
I have more depressed moods	[ ]	[ ]	[ ]	[ ]
I am having mood swings	[ ]	[ ]	[ ]	[ ]
I have crying spells	[ ]	[ ]	[ ]	[ ]
I have headaches	[ ]	[ ]	[ ]	[ ]
I need to urinate more often than usual	[ ]	[ ]	[ ]	[ ]
I leak urine	[ ]	[ ]	[ ]	[ ]
I have pain or burning when urinating	[ ]	[ ]	[ ]	[ ]
I have bladder infections	[ ]	[ ]	[ ]	[ ]
I have uncontrollable loss of stool or gas	[ ]	[ ]	[ ]	[ ]
My vagina is dry	[ ]	[ ]	[ ]	[ ]
I have vaginal itching	[ ]	[ ]	[ ]	[ ]
I have an abnormal vaginal discharge	[ ]	[ ]	[ ]	[ ]
I have vaginal infections	[ ]	[ ]	[ ]	[ ]
I have pain during intercourse	[ ]	[ ]	[ ]	[ ]
I have pain inside during intercourse	[ ]	[ ]	[ ]	[ ]
I have bleeding after intercourse	[ ]	[ ]	[ ]	[ ]
I lack desire or interest in sexual activity	[ ]	[ ]	[ ]	[ ]
I have difficulty achieving orgasm	[ ]	[ ]	[ ]	[ ]
My opportunity for sexual activity is limited	[ ]	[ ]	[ ]	[ ]
My stomach fees like it's bloated or I've gained weight	[ ]	[ ]	[ ]	[ ]
I have breast tenderness	[ ]	[ ]	[ ]	[ ]
I have joint pains	[ ]	[ ]	[ ]	[ ]