

Please complete these forms as thoroughly as possible; a detailed history will help the Doctor assess the best possible approach to improving your well being.

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

Do you have a uterus?..... Yes No Don't know

Do you have both ovaries?..... Yes No Don't know

Do you have a cervix?..... Yes No Don't know

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

Is there a recent change in how often you have periods?..... Yes No

Is there a recent change in how many days you bleed? 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 just prior to your period)

Yes No

Do you examine your breasts?..... Yes No If yes, how often? _____

Have you had breast biopsies in the past? Yes No

Have you noticed skin or nipple changes? Yes No

Have you noticed any lumps in your breasts? Yes No

Have you had breast pain? Yes No

Did your mother take DES when she was pregnant with you? Yes No Don't know

Do you douche?..... Yes No If yes, how often? _____

Obstetrical History

How many times have you been pregnant? _____

How many children do you have? _____

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

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

How did you feel during the 2nd semester of pregnancy? Worse than before you became Pregnant

Better than before you became Pregnant

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: _____

Patient Form – Hormone Assessment

Please indicate the method of birth control, if any, that you are currently using or have used previously:

	Using Now	Previously Used		Using Now	Previously Used
None	<input type="checkbox"/>	<input type="checkbox"/>	Implanted hormone	<input type="checkbox"/>	<input type="checkbox"/>
Sterilization (tubes tied)	<input type="checkbox"/>	<input type="checkbox"/>	Diaphragm	<input type="checkbox"/>	<input type="checkbox"/>
Male partner had vasectomy	<input type="checkbox"/>	<input type="checkbox"/>	Foam/gel	<input type="checkbox"/>	<input type="checkbox"/>
Birth control pill, ring, or skin patch	<input type="checkbox"/>	<input type="checkbox"/>	Condoms	<input type="checkbox"/>	<input type="checkbox"/>
IUD	<input type="checkbox"/>	<input type="checkbox"/>	Natural family planning/rhythm	<input type="checkbox"/>	<input type="checkbox"/>
Injectable hormone	<input type="checkbox"/>	<input type="checkbox"/>			
Other _____	<input type="checkbox"/>	<input type="checkbox"/>			

Sexual History:

Are you currently sexually active?..... Yes No

Have you had any sexually transmitted infections? 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 breasts; 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

Therapeutic History:

Are you currently using hormone therapy for menopause? Yes No

If no, why not? _____

If yes, for what reasons? _____

Have you used any other therapy for menopause (such as acupuncture or yoga)?

Yes No

If yes, please indicate: _____

Of these, what are you currently using? _____

Is this therapy helpful? Yes No

How do you view menopause?

Positively. For example, menopause means no more periods and no more worry about contraception. Menopause marks a new life phase.

Negatively. For example, menopause means a loss of fertility and loss of youth.

Other: _____

What concerns you about menopause? _____

What are your current views regarding hormone therapy for menopause?

Positive. Hormone therapy is appropriate for some women.

Negative. I don't support the use of hormone therapy.

Other: _____

What concerns you most about hormone therapy for menopause? _____

How would you rate your knowledge about menopause?

Very good Fair Moderately good Little knowledge

How do you get your information about menopause? (Mark all that apply.)

Books Internet Magazines Friends TV Healthcare providers

Patient Form – Hormone Assessment

Patient Checklist

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 difficulty getting to sleep				
I have difficulty staying asleep				
I get heart palpitations or a sensation of butterflies in my chest or stomach				
I feel like my skin is crawling or itching				
I feel more tired than 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 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 feels like it's bloated				
I've gained weight				
I have breast tenderness				
I have joint pains				

Is there anything else you would like your healthcare provider to know?
