Initial Personal Health Assessment - Menopause

Today's Date: _____

Name: _____ Date of Birth: _____
(Last) (First) (Middle Initial)
Marital Status _____ Occupation _____
Primary Care Physician: _____ Referred By: _____
What would you like to address at today's visit _____
_____
How did you hear about our office? □ Online search □ Insurance □ Physician □ Family/Friend □ Other

ALLERGIES:
Please note any allergies or reactions to medications or other agents. ❑ None
Allergen and reaction:
_____
_____

CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS: ❑ None
Med/Dose/Instruction: _____
Med/Dose/Instruction: _____
Med/Dose/Instruction: _____
Med/Dose/Instruction: _____
Med/Dose/Instruction: _____
Med/Dose/Instruction: _____

OBSTETRICS HISTORY
Have you ever been pregnant? Yes ❑ No ❑
If yes, how many times? _____ How many children do you have _____
Please list all pregnancies (including miscarriages and abortions):

Pregnancy Outcome (vaginal, Cesarean, VBAC, miscarriage, abortion, ectopic)	Date	Weeks of Gestation	Problems or Complications

MENOPAUSE HISTORY
At what age did your periods start? _____
Date of Last Menstrual Period: _____ Age of menopause: _____
Current hormone replacement therapy (HRT): Yes ❑ No ❑ Total Years of HRT: ____
Vaginal hormone therapy: Yes ❑ No ❑
Postmenopausal bleeding: Yes ❑ No ❑

SEXUAL HISTORY
Are you currently sexually active? Yes ❑ No ❑ If no, have you ever been sexually active? Yes ❑ No ❑
Are your partner(s): Male ❑ Female ❑ Both ❑
Do you or your partner have more than one partner? Yes ❑ No ❑
How many sexual partners have you had in the past year? _____
Do you have concerns about sexually transmitted infections? Yes ❑ No ❑
Do you want to be screened for HIV, or other STD's? No screening ❑ HIV ❑ Other STD screening ❑
Do you have any concerns about sex? Yes ❑ No ❑

LIFESTYLE/PERSONAL HABITS	Yes	No		
Alcohol	❑	❑	Drinks per day: _____	Drinks per week: _____
Marijuana	❑	❑	Days used/week: _____	
Current Drug Use	❑	❑	Type: _____	Days used per week: _____
History of Drug Use	❑	❑	Year of last use: _____	
Current Tobacco Use	❑	❑	Pack per day: _____	Age: _____
History of Tobacco Use	❑	❑	Age quit: _____	
Seat Belt Use	❑	❑		

Describe your diet: ❑Healthy ❑ Average ❑ Poor ❑ Vegetarian/Vegan ❑ Weight Watchers
Describe your exercise: ❑Regularly ❑Occasionally ❑Rarely ❑ Never

Personal Safety	Yes	No
Is there anything in your past that may make your visit today uncomfortable/traumatic/scary?	❑	❑
Have you been emotionally or physically abused by your partner, or someone close to you?	❑	❑
Has anyone ever forced you to have sex or sexual contact?	❑	❑
Are you ever afraid of your partner?	❑	❑
Have you recently felt down, hopeless or had little interest in doing things you enjoy?	❑	❑

PREVENTATIVE CARE

Date of Last Pap: _____ History of Abnormal Paps? ❑ Yes ❑ No Year _____
Date of Last Mammogram: _____ Date of Last Screening Labs (cholesterol, thyroid, diabetes): _____
Date of Last Colonoscopy: _____ Date of Last Bone Scan: _____

Have you ever had any of the following STDs?

❑ Chlamydia ❑ Gonorrhea ❑ Trichomonas ❑ HIV ❑ Genital Herpes ❑ Genital Warts ❑ Hepatitis C
❑ Hepatitis B ❑ Syphilis

Do you or have you had any of the following Gynecologic problems?

❑ Abnormal pap	❑ STI/Sexually Transmitted
❑ DES Exposure (When your mother was pregnant with you)	❑ Pelvic Inflammatory Disease
❑ Endometriosis or Adenomyosis	❑ PMS
❑ Irregular periods	❑ Abnormal Uterine Structure
❑ PCOS	❑ Urine Incontinence
❑ Ovarian Cyst, Type _____	❑ Dysplasia/Precancer: Cervical ❑ Vaginal ❑ Vulvar ❑
❑ Infertility	❑ Recurrent Vaginitis: Yeast ❑ BV ❑
❑ Fibroids	❑ Pain with Sex
❑ Chronic Pelvic Pain	❑ Other _____

Do you have the following medical problems?

❑ Anemia	❑ High blood pressure (Hypertension)
❑ Anxiety	❑ High cholesterol
❑ Arthritis	❑ Kidney infection (Pyelonephritis)
❑ Asthma	❑ Kidney stones
❑ Blood transfusion	❑ Migraines
❑ Cancer, Type _____	❑ Osteopenia
❑ Depression	❑ Osteoporosis
❑ Diabetes	❑ Seizure disorder (Epilepsy)
❑ DVT (Deep venous thrombosis)	❑ Stroke (Cerebrovascular accident)
❑ Endometriosis	❑ Thyroid disorder
❑ GERD (Gastroesophageal reflux)	❑ OTHER medical problems: _____

SURGICAL HISTORY: List all operations (excluding pregnancy): ❑ None

DATE	SURGERY

FAMILY HISTORY: **Adopted** ❑

Illness	Relationship to you	Paternal = P Maternal = M	Details/Comments
Autoimmune Disease (lupus, ulcerative colitis, RA)			
Heart Disease (heart attack, high blood pressure, high cholesterol)			
Cancer - Breast			
Cancer - Colon			
Cancer - Ovarian			
Cancer - Uterine			
Cancer – Other			
Diabetes			
Genetic Disorders (CF, Muscular Dystrophy, Tay Sachs, Fragile X, Thalassemia, Sickle Cell)			
Gynecologic Problem (fibroids, infertility, early menopause, endometriosis)			
Hypercoagulable Disorder (blood clots in legs or lungs)			
Mental Illness/Substance abuse			
Osteoporosis			
Stroke			
Thyroid Disease			
Other			

Immunizations

Have you Received a . . .	**No**	**Yes**	**Date Given:**
Flu Shot this flu season?			
Pneumonia Vaccine?			
Shingles Vaccine?			

REVIEW OF SYSTEMS: (please check if you ***currently*** have any of the following symptoms)**:**

❑ Fatigue	❑ Chest pain	❑ Faint
❑ Weight gain	❑ Persistent cough	❑ Dizzy
❑ Weight loss	❑ Shortness of breath	❑ Anxiety
❑ Easy bruising	❑ Wheezing	❑ Depression
❑ Enlarged glands or lumps	❑ Acid reflux	❑ Headaches
❑ Environmental allergies	❑ Nausea or vomiting	❑ Memory loss
❑ Hot flashes	❑ Abdominal pain	❑ Trouble sleeping
❑ Cold intolerance	❑ Abdominal bloating	❑ Varicose veins
❑ Heat intolerance	❑ Constipation	❑ Muscle or joint pain
❑ Excessive hair loss	❑ Diarrhea	❑ Back pain
❑ Excessive hair growth	❑ Painful urination	❑ Breast pain
❑ Skin rash	❑ Urine incontinence	❑ Breast discharge
❑ Changing moles	❑ Abnormal vaginal discharge	❑ Breast lump
❑ Other _____		