Periodic Personal Health Assessment - Menopause

Today's Date: _____

Name: _____ Date of Birth: _____
(Last) (First) (Middle Initial)
Marital Status _____ Occupation _____
Primary Care Physician: _____
What would you like to address at today's visit _____
_____

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: _____

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 ❑
Are you planning pregnancy in the next year? 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	❑	❑		

Have you been emotionally or physically abused by your partner or someone close to you? Yes ❑ No ❑

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

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 _____

MEDICAL/SURGICAL HISTORY: Since your last exam here, have you had any major health problems or surgery?
No ❑ Yes ❑ Explain: _____
_____

FAMILY HISTORY: Please note any changes in the health of your family since your last visit: ❑ None

_____

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 _____