DR MERCEDES @ WESTCHASE

HEALTH EVALUATION

Hormonal changes are a normal occurrence in a woman's life. Hormonal imbalances may begin as early as 13-14 years old. During a woman's 40 's, a gradual process leading to menopause begins. Women frequently experience symptoms/or several years before menstruation ceases. The stage that comes before menopause is known as perimenopause. Sometimes symptoms are mild and barely noticeable-other times they can be extremely bothersome or distressing.

This questionnaire is intended to help you inform your doctor of any perimenopausal symptoms you may be experiencing. Together you can decide on a course of treatment- and begin discussing the things you need to know about your health.

Name: ____ Age: ___

Last First Middle

Marital Status (circle): M D S W Living with other

Occupation: _______________ Race/Ethnicity: ___________

Menstrual History

Last menstrual period ___________ Age at first menstrual period ________________

Are/were your periods usually ___irregular ____regular Have periods stopped? ___yes ___no

Recent changes in menstrual cycle? ____ yes ____ no

If Yes: Irregular Bleeding ____ yes ____ no

Change in how often you have periods ____ yes ____ no

Changes in how many days you bleed ____ yes ____ no

Changes in flow ____ yes ____ no

Sexual Orientation: ___ Heterosexual ___ Homosexual ___ Bisexual Number of sexual Partners (lifetime): ___

Are you currently sexually active? ____yes ____ no

Method of contraception: ___ Sterilization __ · Pills __ IUD __ Diaphragm __ Foam/gel __ Condoms
___ Natural. Family/Planning /rhythm __ Injectable __ Implant __ None __ Other

Have you lost or gained weight recently? ____yes ____no Usual weight range _____

Have you ever been hit slapped, kicked, or otherwise physically hurt by someone? ____ yes ____ no

Within the last 12 months? ____ yes ____ no

Have you ever been forced to have sexual activities when you did not want to? ____ yes ____ no

Within the last 12 months? ____ yes ____ no

Do you have:

Night sweats	___ frequently	___ sometimes	___ rarely	___ no
Hot flashes/hot flushes	___ frequently	___ sometimes	___ rarely	___ no
Pain with intercourse	___frequently	___sometimes	___rarely	___no
Vaginal dryness	___ frequently	___ sometimes	___ rarely	___ no
Sleeping problems	___ frequently	___ sometimes	___ rarely	___ no
Urine leaks when you cough or sneeze	___ frequently	___ sometimes	___ rarely	___ no
Difficulty concentrating/memory loss				
Mood Swings	___ frequently	___ sometimes	___ rarely	___ no
Migraines	___ frequently	___ sometimes	___ rarely	___ no
Depression	___ frequently	___ sometimes	___ rarely	___ no
Anxiety	___ frequently	___ sometimes	___ rarely	___ no
Decrease in sexual desire	___ frequently	___ sometimes	___ rarely	___ no
Decrease in energy Level	___ frequently	___ sometimes	___ rarely	___ no

How have you dealt with these symptoms?

Herbal medications/supplements ____ yes ____ no Specify ______________________

Changed diet ____ yes ____ no Specify ______________________

Layered Clothing ____ yes ____ no Specify ______________________

Increased exercise ____ yes ____ no Specify ______________________

PERSONAL IDSTORY/HEALTH STATUS

Do you consider your health to be: ___ Excellent ____ Good ____ Fair ____ Poor

Medical illnesses: ____

Surgeries: ____

Allergies: ____

Blood clots in legs: ____ yes ____ no When? ______________________

Fluid Retention: ____ yes ____ no

Bladder/kidney infection: ____ yes ____ no

Monthly breast exam: ____ yes ____ no

Exercise: ____ yes ____ no

Tobacco use: ____ yes ____ no ____ quit

If "yes" or "quit" form/ amount ____________________ How often? __________________________

Caffeine-containing beverages (coffee, tea, cola): ____ yes ____ no

If "yes" how many cups per day? __________

Alcohol: ___ yes ____ no How much? ______ How Often? ______

Street Drugs: ___ yes ____ no How Much? ______ How Often? ______ Specify: ____________

Other drugs or medications: ____ yes ____ no Specify ______________________

Migraines or frequent Headaches: ____ yes ____ no

History of depression: ____ yes ____ no

History of Anxiety: ____ yes ____ no

History of other mental issues: ____ yes ____ no

History of sexually transmitted disease/STD: ____ yes ____ no Specify ________________

Chlamydia: ____ yes ____ no Syphilis: ____ yes ____ no

Gonorrhea: ____ yes ____ no Herpes: ____ yes ____ no

HPV /Warts: ____ yes ____ no Other: ____ yes ____ no

Other issues you would like to discuss:

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Physician's Comments/Recommendations:

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