Central Family Practice
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Name	Date:	Age:

Menopausal Health History

Have you had or do you have any of the following: (Please circle)

Alcoholism/substance abuse
Allergies
Anxiety
Asthma/emphysema
Arthritis
Blood in stool
Cancer
Chronic skin problems/rash
Colitis
Constipation
Depression
Diabetes
Diarrhea
Difficulty achieving orgasm
Difficulty swallowing
Diverticulitis
Double/blurred vision
Epilepsy/seizures
Exposure to HIV
Frequent or severe headaches
Gall bladder problem
Heart attack
Heat disease
Hepatitis
Hernia (type) _____
High blood pressure
High cholesterol
Impotence
Kidney or bladder infection
Kidney stone
Loss of hearing
Loss of vision
Night sweats
Osteoporosis
Pneumonia
Positive TB skin test
Rheumatic fever
Sexually transmitted disease:
- Gonorrhea
- Chlamydia
- Syphilis
- Herpes
- HPV/warts

Sinus problems
Stroke
Swelling in legs or feet
Tuberculosis
Thyroid problems
Vomiting of blood
Weight loss/gain

Are you experiencing any health problems today? If so, please describe: _____

_____

Please list any surgeries or hospitalization: _____

_____

Please list any medication allergies: _____

Please list medications, herbs, and vitamins taken on a regular basis: _____

_____

Menstrual/Pregnancy History

Age of first period _____
Usual length of period _____ days
Are you currently trying to get pregnant?

Usual interval between periods _____
Age of first intercourse: _____
Yes No

Number of: Pregnancy: ____ Still births: ____ Abortion/miscarriage: ____ Full-term deliveries:____

Have you had any of the following: (please circle)

Irregular periods
Painful periods
Infection in ovaries
Abnormal breast lumps
Abnormal pap smear
DES exposure
Infection in fallopian tubes
Ovarian cysts

Which of the following contraceptive methods have you used: (please circle)

IUD
Diaphragm
Birth control pills
Condoms
Foam
Vasectomy
Tubal ligation
None
Other
_____
None, same sex preference
Natural family planning

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

Have your parents, siblings, or grandparents ever had any of the following: (please circle)

Diabetes	Alcoholism/	Osteoporosis
Cancer	substance abuse	Depression
type _____	Heart Disease	Sickle cell trait/disease
Stroke	Thyroid problems	High cholesterol

Sleeping Habits

Are you having difficulty sleeping?	Yes	No
Is stress in your life causing you to lose sleep?	Yes	No
Have your sleeping habits changed recently?	Yes	No

Eating Habits

Have you gained or lost a significant amount of weight recently?	Yes	No
If yes, how much? _____		
Are you concerned about your current eating habits?	Yes	No
Do you consider your diet healthy?	Yes	No
Are you having problems with over-eating?	Yes	No
Do you think you may have an eating disorder?	Yes	No

Personal Habits

Do you smoke cigarettes?	Yes	No	How many per day? _____
Do you have regular bowel movements?	Yes	No	How often? _____
Do you exercise regularly?	Yes	No	
Do you drink alcohol?	Yes	No	
Do you feel overly stressed in your daily life?	Yes	No	
Are you currently experiencing any feeling of depression?	Yes	No	

Have you recently experienced any events that increase your stress level? Please describe: _____

_____

Menopausal Symptoms:

Please rate all that apply from 1-10, with #1 being barely noticeable to #10 being unendurable.

Abdominal bloating _____
Allergies _____
Anxiety _____
Angry _____
Appetite increase _____
Appetite decrease _____
Bleeding and spotting (not menses) _____
Breast tenderness and swelling _____
Craving sweets and starches _____
Craving salt and fat _____
Craving (other) specific _____
Constipation _____
Crying _____
Depression or sadness _____
Diarrhea _____
Fatigue _____
Headaches _____
Heavy menstrual bleeding _____
Hot flashes _____
Irritable _____
Insomnia _____
Menstrual cramps _____
Moody _____
Nausea _____
Night sweats _____
Sexual pleasure/arousal (inc/dec) _____
Swelling _____
Trouble concentrating/remembering _____
Vaginal dryness _____