

Central Family Practice
 801 W. 34th Street, Suite 102
 Austin, TX 78705
 (512)371-9260

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 interval between periods _____
 Usual length of period _____ days Age of first intercourse: _____
 Are you currently trying to get pregnant? Yes No
Number of: Pregnancy: ____ Still births: ____ Abortion/miscarriage: ____ Full-term deliveries: ____

- Have you had any of the following:** (please circle)
- | | | |
|----------------------|-----------------------|------------------------------|
| Irregular periods | Abnormal breast lumps | Infection in fallopian tubes |
| Painful periods | Abnormal pap smear | Ovarian cysts |
| Infection in ovaries | DES exposure | |

- Which of the following contraceptive methods have you used:** (please circle)
- | | | |
|---------------------|----------------|---------------------------|
| IUD | Foam | Other _____ |
| Diaphragm | Vasectomy | |
| Birth control pills | Tubal ligation | None, same sex preference |
| Condoms | None | 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? If yes, how much? _____	Yes	No
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 _____	Fatigue _____
Allergies _____	Headaches _____
Anxiety _____	Heavy menstrual bleeding _____
Angry _____	Hot flashes _____
Appetite increase _____	Irritable _____
Appetite decrease _____	Insomnia _____
Bleeding and spotting (not menses) _____	Menstrual cramps _____
Breast tenderness and swelling _____	Moody _____
Craving sweets and starches _____	Nausea _____
Craving salt and fat _____	Night sweats _____
Craving (other) specific _____	Sexual pleasure/arousal (inc/dec) _____
Constipation _____	Swelling _____
Crying _____	Trouble concentrating/remembering _____
Depression or sadness _____	Vaginal dryness _____
Diarrhea _____	