Avenues for Health
Perimenopause/Menopause Consultation Questionnaire

Name _____ Date _____

Briefly describe your symptoms or concerns regarding peri/menopause

_____
_____
_____
_____

Date of Last Menstrual Period_____
Have you had your ovaries or uterus surgically removed? _____
Are you currently on birth control pills? __ Yes __No Type_____

If on hormones, list the Rx or compounds you are currently on

Hormone Tablet/patch/cream/gel strength/dose Frequency

_____
_____
_____

Do you have:

Night Sweats	__ frequently __ rarely __ no
Hot Flashes/Flushes	__ frequently __ rarely __ no
Sleep Problems	__ frequently __ rarely __ no
Fatigue	__ frequently __ rarely __ no
Mood Swings	__ frequently __ rarely __ no
Depression	__ frequently __ rarely __ no
Anxiety	__ frequently __ rarely __ no
Difficulty concentrating	__ frequently __ rarely __ no
Pain with sex	__ frequently __ rarely __ no
Vulva/labia burning	__ frequently __ rarely __ no
Vaginal dryness	__ frequently __ rarely __ no
Decreased sexual libido	__ frequently __ rarely __ no
Decreased sexual response	__ frequently __ rarely __ no
Joint pain/stiffness	__ frequently __ rarely __ no
Headaches	__ frequently __ rarely __ no
Urinary frequency	__ frequently __ rarely __ no
Urinary incontinence	__ frequently __ rarely __ no
Weight gain	__ more than 20 lbs __ 10-20lbs __ less than 10 lbs

Other_____

Circle the 3 symptoms above that bother you most

PERSONAL HISTORY/HEALTH STATUS

Do you consider your health to be: Excellent Good Fair Poor
Occupation: _____
Marital Status (circle): S M D W Partnered
Do you have children? __ Yes __ No Ages _____

Are you currently sexually active? __ Yes __ No
Are you in a monogamous relationship? __ Yes __ No
Are your partner(s) __ Men __ Women __ Both
Do you want to be screened for sexually transmitted infections? __ Yes __ No

Allergies_____

Medications (include doses)
_____
_____
_____

If applicable, Method of Contraception:
__ Birth Control Pill/ring/patch __ IUD __ Nexplanon __ Condom
__ Vasectomy __ Tubal Ligation __ Natural family Planning __ none

Medical Illnesses_____
_____
_____

Surgeries_____
_____
_____

Check if you have
__High cholesterol
__ High blood sugar
__ High Blood Pressure
__Low Bone Density
__ History of Cancer Specify_____
__ Migraine or frequent Headaches
__ History of Depression
__ History of Anxiety
__ History of Insomnia

List all Supplements (include doses)
_____
_____
_____
_____

Lifestyle

Exercise Type(s)_____
How often? _____
Meditation or Yoga __ Yes __ No
Smoking __ Yes __ No Quit date_____ How many cig/packs per day? _____
Alcohol __ Daily __ more than 4 drinks per wk __ Less than 4 drinks per wk
(Confidential) Other drugs __ Yes __ No type _____
Stress management __ Very Effective __ Effective __ suboptimal __ Poor

Diet/ Nutrition self-assessment

__ Very Healthy __ moderately Healthy __ Fair __ Poor
Special dietary choices_____

Check if you have had the following Screening Tests?

__ Colonoscopy date_____
__ Mammogram date _____
__ Breast Ultrasound date _____
__ Bone Density date _____
__ Cholesterol Profile date _____

Family History

Please indicate if your parents, grandparents, aunts/ uncles, siblings or children have had

Cancer:	**Medical Conditions:**	
Breast_____	Heart Attack_____	Mental Illness_____
Ovarian_____	High Blood Pressure_____	Alcoholism_____
Colon_____	Stroke_____	Alzheimer's_____
Uterine_____	Osteoporosis_____	Blood Clots _____
Melanoma_____	Diabetes _____	Obesity _____
Stomach/Pancreas _____		

Other_____

What have you tried to manage your symptoms?

□ Supplements specify _____
_____
□ Herbs specify _____
_____
□ Exercise specify _____
□ Acupuncture specify _____
□ Biofeedback specify _____
□ Dietary changes specify _____
□ Meditation/Yoga specify_____
□ Layered clothing, fans, etc _____
Other _____

What concerns you about using hormone therapy?

__ Breast Cancer	__ Emotional Effect
__ Weight Gain	__ Heart Disease
__ Continued periods	__ Blood clots_
__ Uterine Cancer	__ Headache/migraine
__ Ovarian Ca	__ Return of symptoms when stop HT

If you have been on other hormone therapy in the past, please list

Hormone strength/dose Date Why you stopped it

_____

_____

_____

_____

Any problems with your current or past Hormone regimen?

_____

_____

_____

Have you had?

__Recent changes in your menstrual cycle

__Irregular Bleeding

__Bleeding in between periods or after intercourse

__Changes in the number of days of bleeding __ Longer __ Shorter

__Changes in flow __Flooding __ Heavy __ Moderate __ Light

__Cramps __ Mild __ Moderate __ Severe

Any other specific concerns or questions that you would like to discuss?

_____

_____

_____