Menopause Health Profile

Your answers on this form will help the Menopause clinic team to better understand your concerns and medical conditions. Best estimates are fine, if you cannot remember specific details.

Personal Information

Name:	
Address:	
Phone:	Email:
AB Health Care Number:	
Date of Birth:	Age:
Family Doctor:	

Your Clinic Visit

What are your main concerns or questions that you would like addressed during your visit?

Personal Medical History

Please check if you currently have or have a history of any of the following:

□ Breast cancer	□ Depression	□ Osteoporosis
□ Colon cancer	□ Postpartum depression	□ Irritable bowel syndrome
□ Other cancer:	□ Mood changes in pregnancy	□ Ulcerative colitis
		□ Crohn's disease
□ Diabetes	□ Anxiety	□ Celiac disease
□ Heart disease	□ Bipolar disease	□ Rheumatoid arthritis
□ High blood pressure	□ Schizophrenia	□ Osteoarthritis
□ High cholesterol	□ Fibromyalgia	□ Thyroid disease
□ Blood clots	□ Chronic fatigue syndrome	□ Hyperparathyroidism
□ Clotting disorder	□ Liver disease	□ Asthma
□ Stroke	□ Kidney disease	□ Migraines
□ Seizures	□ Gall bladder disease	□ Anemia
	□ Varicose veins	

Please tell us about any other medical conditions that you have been under the care of a physician for the last five years: _____

_____

PALISADES PHARMACY

Gynecological History

Date of last menstrual period: _____

When was the last time you had a Pap smear? ☐ < 1 year ☐ 1 – 2 years ☐ > 2 years

Are your periods: ☐ Regular ☐ Irregular ☐ None for 12 months or longer

If not having periods:

Have you had a hysterectomy? ☐ Yes ☐ No

If yes, when? _____ What was the reason? _____

Have you had your ovaries removed? ☐ Yes ☐ No

If still having periods:

How many days between your periods? _____

How long do your periods last? _____

Have your periods changed in the last year? ☐ Yes ☐ No

If yes, please tell us how. *Check all that apply:*

☐ Bleeding more often
☐ Bleeding less often
☐ Lighter flow
☐ Heavier flow
☐ Heavy flow with clots
☐ Spotting or bleeding between periods

Before your periods began to change, were they: ☐ Regular ☐ Irregular

Are your periods painful? ☐ Yes ☐ No

If yes, how painful? ☐ Mild ☐ Moderate ☐ Severe

Do you have any vaginal bleeding with intercourse? ☐ Yes ☐ No

Do you experience PMS? ☐ Yes ☐ No

Please describe symptoms _____

_____

When does it start? ☐ 1 – 3 days before period ☐ < 1 week before period ☐ 1 – 2 weeks before period ☐ All month

How long do the symptoms last? _____

Please check if you have a history of any of the following:

☐ Fibroids
☐ Endometriosis
☐ Pelvic pain
☐ Abnormal pap test
☐ Cancer of the uterus
☐ Cancer of the ovaries
☐ Cancer of the cervix

Obstetrical History

How many pregnancies have you had? _____ Number of live births? _____

Did you have any complications with your pregnancies? ☐ Yes ☐ No

Sexual History

Are you currently sexually active? ☐ Yes ☐ No

If using birth control, what method are you using? _____

Do you have any concerns about your sex life? ☐ Yes ☐ No

Please describe_____

Have you used birth control pills in the past? ☐ Yes ☐ No

If yes, how long did you take them? _____

Did you have any side effects? ☐ Yes ☐ No If yes, please list _____

Symptoms

	Severe	Moderate	Mild	None
VASOMOTOR SYMPTOMS				
Hot flashes				
Night sweats				
SLEEP				
Difficulty getting to sleep				
Difficulty staying asleep or wake frequently				
Restless legs				
MOOD				
Tired				
Irritable				
Anxiety or panic				
Depressed				
Mood swings				
Loss of confidence				
COGNITION				
Memory is poor				
Difficulty concentrating				
UROGENITAL				
Vaginal dryness or itching				
Change in vaginal discharge				
Vaginal infections				
Urinate more often than usual				
Leak urine when sneeze, cough, exercise				
Strong need to urinate (hard to reach toilet in time)				
Pain or burning with urination				
Bladder infections				
SEXUAL				
Lack of desire or interest in sexual activity				
Difficulty achieving orgasm				
Pain during intercourse				

	Severe	Moderate	Mild	None
OTHER				
Headaches or migraines				
Light headed or dizzy				
Breast tenderness				
Bloated				
Skin feels like it is crawling or itching				
Hair loss				
Uncontrollable loss of stool or gas				
New facial hair				
Muscle or joint pain				
Heart palpitations				

Are there times when your symptoms seem worse (e.g. just before your period, during your period, during times of stress, etc)? Please describe _____

_____

Is something happening in your life that you feel may be affecting your symptoms? _____

_____

Management of Symptoms:

Are you currently using any of the following therapies for your menopausal symptoms?

- □ Hormone Therapy
- □ Hormone contraceptive (ex. Birth control pill)
- □ Other prescriptions (ex. Antidepressants, clonidine, gabapentin)
- □ Soy, vitamin, herbs, supplements
- □ Acupuncture
- □ Changes in diet
- □ Change in exercise
- □ Relaxation strategies

If currently or previously using any of the therapies, what are they and are they helpful? _____

_____

_____

Medication history

Medication	Dose	How I take it	Date Started

Risk Factor Review

The following questions will help us assess your risk for disease later on in life.

Please check all that apply to you:

Family History

□ Breast cancer	□ Osteoporosis	□ Depression
□ Ovarian cancer	□ Stroke	□ Other psychiatric illness
□ Uterine cancer	□ Blood clots	□ Bleeding tendency
□ Colorectal cancer	□ Heart disease	□ Alzheimer's disease
□ Other cancer:	□ High blood pressure	□ Thyroid disease
	□ Diabetes	

Osteoporosis risk

Major risk factors for osteoporosis:	Minor risk factors for osteoporosis:
□ Age 65 or older □ Family history of osteoporosis □ Broke bone after age 40 □ Fractures in the spine □ Loss of height of greater than 4cm (1.5inches) since age 25 □ Menopause or ovaries removed before age 45 □ Loss of periods for longer than several months (other than pregnancy or menopause) □ Use of prednisone or similar for more than 3 months □ Osteopenia diagnosed by X-ray □ Celiac disease or Crohn's disease □ Hyperparathyroidism □ Tendency to fall	□ Rheumatoid arthritis □ History of or current high thyroid □ Low body weight (<125lb) □ Current smoker □ Low calcium intake □ Low vitamin D intake □ Greater than four cups of coffee, tea or cola per day □ Greater than two drinks of alcohol per day □ Use of one of the following medications for more than 3 months □ Heparin □ Anti-seizure medication

Have you had a bone mineral density (BMD) test? □ Yes □ No Date:_____

Breast cancer risk

□ Mother or sister diagnosed with breast cancer before menopause	□ Overweight
□ Previous breast, uterine or ovarian cancer	□ Weight gain of 50lb after menopause
□ Positive BRCA1 or 2 gene mutation	□ Drink more than seven alcohol drinks per week
□ Late menopause (after 55)	□ Do not exercise regularly
□ First period before age 12	□ Diet low in fruit and fibre
□ Had first child after 30	□ Hormone therapy longer than five years
□ Did not have children	

How often do you have mammograms? □ Never □ Yearly □ Every two years Other

When was your last mammogram? _____

Heart Health

☐ Age 65 or older	☐ Diabetes
☐ Family history of heart disease	☐ High fasting blood sugar
☐ Previous heart attack	☐ Current smoker
☐ Previous stroke	☐ Overweight or obese
☐ Previous or current chest pain (angina)	☐ My shape is like an apple (waist bigger than hips)
☐ Previous or current heart rhythm problem	☐ Exercise less than three times per week
☐ High blood pressure	☐ High fat diet
☐ High total cholesterol	
☐ Low HDL (good) cholesterol	
☐ High triglycerides	

Have you had a fasting cholesterol test? ☐ Yes ☐ No Date:_____

What is your blood pressure usually?

Personal Life

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other relationship

Employment: ☐ Not working ☐ Full time ☐ Part time ☐ Retired ☐ On leave

Occupation: _____

Educated completed: ☐ Less than 12 years ☐ High school diploma ☐ Post secondary

In general, would you say your health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please tell us about any recent changes that have happened in your life: _____

_____

Sleep

How many hours of sleep do you get each night? ☐ 1 – 2 ☐ 3 – 4 ☐ 5 – 6 ☐ 7 – 8 ☐ > 8

Have you sleep patterns changed recently? _____

Do you take anything to help you sleep? ☐ Yes ☐ No

If yes, what? _____

Leisure activities

Do you participate regularly in leisure activities that you enjoy? ☐ Yes ☐ No

Do you feel you have enough time to do the things you enjoy? ☐ Yes ☐ No

Do you see your friends and family as often as you like? ☐ Yes ☐ No

Stress management

Do you currently feel under a lot of stress? ☐ Yes ☐ No

If yes, what is causing your stress? ☐ Work ☐ Family life ☐ Partner/relationship ☐ Other

How do you handle stress? ☐ Well ☐ Sufficiently ☐ Poorly

Please describe the ways that you manage your stress:_____

_____

Are you in a relationship where you feel emotionally or physically abused by your partner or someone close to you? ☐ Yes ☐ No ☐ In the past

Tobacco use

Do you currently smoke? ☐ Yes ☐ No If yes, how many cigarettes per day? _____

How long have you smoked? _____

If you are a past smoker, when did you quit? _____

Alcohol use:

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many drinks per week? ☐ < 1 ☐ 1 – 3 ☐ 4 – 7 ☐ > 7

Do you drink more when you feel stressed? ☐ Yes ☐ No

Recreational drug use:

Do you use cannabis? ☐ Yes ☐ No

If yes, how many times per week? ☐ < 1 ☐ 1 – 3 ☐ 4 – 7 ☐ > 7

Do you use any other forms of recreational drugs? _____

Exercise:

How often do you exercise? ☐ None ☐ Seldomly ☐ 1 – 5 times per week ☐ Daily

If you exercise, what do you do? _____

Weight:

How much do you weigh? _____

How tall are you? _____

Has your weight changed recently? ☐ Gain ☐ Loss How much? _____ ☐ No

If yes, was your weight change planned? ☐ Yes ☐ No

Diet:

Do you follow a specific type of diet? ☐ No ☐ Vegetarian ☐ Vegan ☐ Paleo ☐ Keto

☐ Other: _____

Allergies/Intolerences:

Do you have any allergies? ☐ Yes ☐ No

If yes, please list them along with your reaction to them: _____

_____

_____

_____

Additional information:

How did you hear about us?

☐ Sigma Canadian Menopause Society

☐ NAMS The Menopause Society

☐ Social media

☐ Website

☐ Referral/Word of mouth

☐ Other: _____