Holland Hospital

Welcome to the Women's Specialty Care & High Risk Breast Clinic. Please complete the new patient paperwork and return at least 1 week prior to your appointment via:

1. Mail: 844 Washington Ave, Suite 2700, Holland, MI 49423
2. Email: womenshealth@hollandhospital.org
3. Fax: 616-395-8772

Please reach out to our office with any questions or concerns 616-748-5785.

NAMS
THE NORTH AMERICAN MENOPAUSE SOCIETY

# Menopause Health Questionnaire

Menopause is a normal event in a woman's life and is marked by the end of menstrual periods. Usually during the 40s, a gradual process leading to menopause begins. This is called the menopause transition or perimenopause. Changes in the pattern of menstrual periods are very common during this stage. Sometimes a woman can have other symptoms too, and these symptoms may extend beyond menopause. Even if a woman has no symptoms, it's important for her to understand the effects of menopause on her health.

This questionnaire is intended to help you inform your healthcare provider about your menopause experience and your general health. Working together, you can develop a plan to support your health, not only now but also in years to come. If you feel uncomfortable answering any of the questions on this form, you may wait and discuss them with your healthcare provider.

## Section 1. PERSONAL INFORMATION

Date:

Name:

Address:

Telephone number (home): | Telephone number (work):

Telephone number (cell): | Birth date: | Age:

Ethnic/cultural background (please check what applies to you):

❑ Caucasian ❑ Black ❑ Asian ❑ Native American ❑ Biracial ❑ Hispanic/Latina

❑ Other (please specify)

Marital status (circle): Single Married Divorced Widowed Committed relationship

Name of primary support person:

Relationship:

Primary support person telephone number:

Employment status (circle): Unemployed Employed Retired Disabled

If employed, occupation:

Are you on medical leave: ❑ Yes ❑ No If yes, why? | For how long?

Who is your primary healthcare provider?

Address: | Telephone number:

## Section 2. TODAY'S OFFICE VISIT

Why are you here today?

What are your main concerns or questions you would like to have answered during your visit?

Who referred you?

## Section 3. HEIGHT AND WEIGHT INFORMATION

| | |
|---|---|
| What is your height? | |
| What is your maximum remembered height? | How old were you then? |
| What is your weight? | |
| What is your maximum remembered weight? | How old were you then? |
| What is your lowest remembered weight as an adult? | How old were you then? |

## Section 4. MEDICAL HISTORY

*Please check if you have had problems with:*

- ❑ Migraines
- ❑ Blood Pressure
- ❑ Stroke
- ❑ Cholesterol
- ❑ Heart Attack
- ❑ Chest pain
- ❑ Blood clots
- ❑ Varicose veins
- ❑ Easy bruising
- ❑ Anemia
- ❑ Indigestion
- ❑ Frequent nausea or vomiting
- ❑ Colitis
- ❑ Diarrhea
- ❑ Constipation
- ❑ Bloody or black bowel movements
- ❑ Hepatitis
- ❑ Liver
- ❑ Gallbladder
- ❑ Incontinence (urine or feces)
- ❑ Breasts
- ❑ Endometriosis
- ❑ Fibroids
- ❑ Infertility
- ❑ Cancer
- ❑ Diabetes
- ❑ Thyroid
- ❑ Asthma
- ❑ Arthritis
- ❑ Muscle or joint pain
- ❑ Back pain
- ❑ Seizures
- ❑ Eyesight
- ❑ Macular degeneration
- ❑ Cataracts
- ❑ Depression
- ❑ Anxiety
- ❑ Stress
- ❑ Fatigue
- ❑ Sleeping
- ❑ Dizziness
- ❑ Mood swings
- ❑ Suicidal thoughts
- ❑ Teeth or gums
- ❑ Hair loss or growth
- ❑ Skin
- ❑ Frequent falling
- ❑ Losing height
- ❑ Broken bones
- ❑ Weight loss or gain

Other health problems (describe):

## Section 5. MAJOR ILLNESS AND INJURY HISTORY

| Date | List dates of all operations, hospitalizations, psychological therapy, major injuries, and illnesses (excluding pregnancy). |
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(Please continue on back, if needed.)

## Section 6. GYNECOLOGIC HISTORY

How would you describe your current menstrual status?

- ❑ Premenopause (before menopause; having regular periods)
- ❑ Perimenopause/menopause transition (changes in periods, but have not gone 12 months in a row without a period)
- ❑ Postmenopause (after menopause)

  Was your menopause:

  - ❑ Spontaneous ("natural")
  - ❑ Surgical (removal of both ovaries)
  - ❑ Due to chemotherapy or radiation therapy; reason for therapy: _____
  - ❑ Other (explain): _____

Age at first menstrual period: _____

Are your periods (or were your periods) usually regular?..... ❑ Yes ❑ No

Do you have a uterus?..... ❑ Yes ❑ No ❑ Don't know

Do you have both ovaries?..... ❑ Yes ❑ No ❑ Don't know

Do you have a cervix?..... ❑ Yes ❑ No ❑ Don't know

If not still having periods, what was your age when you had your last period? _____

If still having periods, how often do they occur? _____

How many days does your period last? _____

Are your periods painful? ❑ Yes ❑ No If yes, how painful? ❑ Mild ❑ Moderate ❑ Severe

Do you have spotting or bleeding between periods?..... ❑ Yes ❑ No

Is there a recent change in how often you have periods?..... ❑ Yes ❑ No

Is there a recent change in how many days you bleed? ..... ❑ Yes ❑ No

Has your period recently become very heavy?..... ❑ Yes ❑ No

Do you think you have a problem with your period?..... ❑ Yes ❑ No

If yes, explain: _____

Do you have any problems with PMS? (PMS is having mood swings, bloating, headaches just prior to your period) ❑ Yes ❑ No

Do you examine your breasts?..... ❑ Yes ❑ No If yes, how often? _____

Did your mother take DES when she was pregnant with you? ❑ Yes ❑ No ❑ Don't know

Do you douche?..... ❑ Yes ❑ No If yes, how often? _____

What is the date and results (if known) of your last test regarding:

Pap smear: _____ Any abnormal Pap tests? ❑ Yes ❑ No If yes, when? _____

Mammogram: _____ Any breast biopsies? ❑ Yes ❑ No If yes, when? _____

Thyroid: _____ Any abnormal thyroid tests? ❑ Yes ❑ No If yes, when? _____

Cholesterol test: _____ Colonoscopy: _____

Blood sugar test: _____ Sigmoidoscopy: _____

Fecal occult blood test: _____ Bone density test: _____

## Section 7. OBSTETRICAL HISTORY

Please indicate the method of birth control, if any, that you are currently using or have used previously:

| | Using Now | Previously Used | | Using Now | Previously Used |
|---|---|---|---|---|---|
| None | ❑ | ❑ | Implanted hormone | ❑ | ❑ |
| Sterilization (tubes tied) | ❑ | ❑ | Diaphragm | ❑ | ❑ |
| Male partner had vasectomy | ❑ | ❑ | Foam/gel | ❑ | ❑ |
| Birth control pill, ring, or skin patch | ❑ | ❑ | Condoms | ❑ | ❑ |
| IUD | ❑ | ❑ | Natural family planning/rhythm | ❑ | ❑ |
| Injectable hormone | ❑ | ❑ | Other | ❑ | ❑ |

How many times have you been pregnant?

How many children do you have? | How many were adopted?

How old were you when you first child was born? | How old were you when your last child was born?

Please provide the number of your:

Full term births: Premature births: Miscarriages: Abortions: Living children:

Any complications during pregnancy, delivery, or postpartum? ❑ Yes ❑ No

If yes, please describe:

## Section 8. SEXUAL HISTORY

Are you currently sexually active? ..... ❑ Yes ❑ No

If yes, are you currently having sex with: ❑ A man (or men) ❑ A woman (or women) ❑ Both men and women

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

Are you in a committed, mutually monogamous relationship? .... ❑ Yes ❑ No

If no, do you use condoms (practice safe sex)? ..... ❑ Yes ❑ No

In the past, have you had sex with: ..... ❑ A man (or men) ❑ A woman (or women)

Have you had any sexually transmitted infections? ..... ❑ Yes ❑ No

Do you have concerns about your sex life? ..... ❑ Yes ❑ No

Do you have a loss of interest in sexual activities (libido, desire)? ❑ Yes ❑ No

Do you have a loss of arousal (tingling in the genitals or breasts; vaginal moisture, warmth)? ..... ❑ Yes ❑ No

Do you have a loss of response (weaker or absent orgasm)? .... ❑ Yes ❑ No

Do you have any pain with intercourse (vaginal penetration)? .... ❑ Yes ❑ No

If yes, how long ago did the pain start? _____

Please describe the pain: ❑ Pain with penetration ❑ Pain inside ❑ Feels dry

## Section 9. ALLERGY INFORMATION

Are you allergic to any medications? ❑ Yes ❑ No ❑ Don't know If yes, please indicate which one(s):

Medication: Reaction:

Medication: Reaction:

Medication: Reaction:

Do you have any other allergies? ❑ Yes ❑ No ❑ Don't know If yes, please indicate:

To what? Reaction:

To what? Reaction:

## Section 10. MEDICATION HISTORY

Are you currently using hormone therapy for menopause? ❑ Yes ❑ No

If no, why not?

If yes, for what reasons?

Please indicate the medications and supplements (such as vitamins, calcium, herbs, soy) you are currently using. Include prescription drugs and those purchased without a prescription. Also include all hormone therapy you have used in the past (examples include contraceptives, thyroid hormones, and hormone therapy for menopause).

| Medication/ Supplement | Dose | Frequency | Date Started | Date Stopped | Why Stopped |
|---|---|---|---|---|---|
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Have you used any other therapy for menopause (such as acupuncture or yoga)?

❑ Yes ❑ No If yes, please indicate:

Of these, what are you currently using?

Is this therapy helpful? ❑ Yes ❑ No

## Section 11. FAMILY HISTORY

Please list family member (ie, mother, father, sister, brother, grandparent, aunt, uncle) who currently has or once had the following:

High blood pressure:

Heart attack (indicate age):

Stroke (indicate age):

Blood problems (including sickle cell trait):

Blood clots:

Bleeding tendency:

Glaucoma:

Osteoporosis:

Hip fracture:

Diabetes:

Breast cancer (indicate age):

Colorectal cancer:

Ovarian cancer:

Other cancer:

Depression:

Other emotional problems:

Alzheimer's disease:

Domestic violence victim:

Domestic violence person:

Sexual abuse victim:

Sexual abuse person:

Alcoholism:

Drug abuse:

Is there anything about your family's health history that concerns you, or that you would like to discuss?

❑ Yes ❑ No If yes, what?

## Section 12. PERSONAL HABITS

**Do you consider your health to be:** ❑ Excellent ❑ Good ❑ Fair ❑ Poor

**Exercise**

How often do you exercise? ❑ Almost daily ❑ At least 3x/week ❑ Occasionally ❑ Rarely ❑ Never

If you exercise, what do you do? _____

For how long and how often?

**Diet**

How many meals do you consume each day? _____

Do you try to eat a special diet? ❑ Low-fat ❑ Low carbohydrate ❑ High protein ❑ Vegetarian

What dairy products do you consume each day?

❑ Milk How much? _____ ❑ Yogurt How much? _____

❑ Cheese How much? _____ ❑ Other _____

Are you lactose intolerant (diarrhea or gastrointestinal/GI upset after dairy products)? ❑ Yes ❑ No

How many servings of fruits do you consume each day? _____

How many servings of vegetables do you consume each day? _____

How many servings of soy foods do you consume each week? _____

How many servings of fish do you consume each week?

**Tobacco use**

Do you currently smoke cigarettes? ❑ Yes ❑ No

If yes, how many per day? _____ When did you start? _____

How do you feel about quitting smoking? _____

If you do not currently smoke cigarettes, have you ever smoked? ❑ Yes ❑ No

If yes, when did you start? _____ How many per day? _____ When did you stop? _____

Do you use any other type of tobacco? ❑ Yes ❑ No If yes, what?

**Caffeine use**

Do you consume drinks with caffeine (coffee, tea, soda drinks)? ❑ Yes ❑ No

If yes, how many drinks each day?

**Alcohol and drug use**

Do you drink alcohol?..... ❑ Yes ❑ No

If yes, how many drinks do you have each week? _____

Do you ever have a drink in the morning to get you going?..... ❑ Yes ❑ No

Have you ever tried to cut down on your drinking?..... ❑ Yes ❑ No

Have you ever felt guilty about the amount you drink?..... ❑ Yes ❑ No

Have you ever been an alcoholic?..... ❑ Yes ❑ No

Do you use illegal drugs?..... ❑ Yes ❑ No

**Abuse**

Within the last year, have you been hit, slapped, kicked, or physically hurt by someone?..... ❑ Yes ❑ No

Within the last year, has anyone ever forced you to have sexual activities? ..... ❑ Yes ❑ No

Do you feel you are verbally or emotionally abused by someone? ❑ Yes ❑ No

Have you had counseling for these issues?..... ❑ Yes ❑ No

**Stress management**

What are the current major stressors or life changes in your life?

Any major changes in the family health during the past year? ❑ Yes ❑ No

If yes, explain:

How do you handle stress? ❑ Very well ❑ Moderately well ❑ Poorly

What do you do to relax?

## Section 13. SYMPTOMS

Please indicate how bothered you are now and in the past few weeks by any of the following:

| | Not at all | A little bit | Quite a bit | Extremely |
|---|---|---|---|---|
| I have hot flashes | ❑ | ❑ | ❑ | ❑ |
| I have night sweats | ❑ | ❑ | ❑ | ❑ |
| I have difficulty getting to sleep | ❑ | ❑ | ❑ | ❑ |
| I have difficulty staying asleep | ❑ | ❑ | ❑ | ❑ |
| I get heart palpitations or a sensation of butterflies in my chest or stomach | ❑ | ❑ | ❑ | ❑ |
| I feel like my skin is crawling or itching | ❑ | ❑ | ❑ | ❑ |
| I feel more tired than usual | ❑ | ❑ | ❑ | ❑ |
| I have difficulty concentrating | ❑ | ❑ | ❑ | ❑ |
| My memory is poor | ❑ | ❑ | ❑ | ❑ |
| I am more irritable than usual | ❑ | ❑ | ❑ | ❑ |
| I feel more anxious than usual | ❑ | ❑ | ❑ | ❑ |
| I have more depressed moods | ❑ | ❑ | ❑ | ❑ |
| I am having mood swings | ❑ | ❑ | ❑ | ❑ |
| I have crying spells | ❑ | ❑ | ❑ | ❑ |
| I have headaches | ❑ | ❑ | ❑ | ❑ |
| I need to urinate more often than usual | ❑ | ❑ | ❑ | ❑ |
| I leak urine | ❑ | ❑ | ❑ | ❑ |
| I have pain or burning when urinating | ❑ | ❑ | ❑ | ❑ |
| I have bladder infections | ❑ | ❑ | ❑ | ❑ |
| I have uncontrollable loss of stool or gas | ❑ | ❑ | ❑ | ❑ |
| My vagina is dry | ❑ | ❑ | ❑ | ❑ |
| I have vaginal itching | ❑ | ❑ | ❑ | ❑ |
| I have an abnormal vaginal discharge | ❑ | ❑ | ❑ | ❑ |
| I have vaginal infections | ❑ | ❑ | ❑ | ❑ |
| I have pain during intercourse | ❑ | ❑ | ❑ | ❑ |
| I have pain inside during intercourse | ❑ | ❑ | ❑ | ❑ |
| I have bleeding after intercourse | ❑ | ❑ | ❑ | ❑ |
| I lack desire or interest in sexual activity | ❑ | ❑ | ❑ | ❑ |
| I have difficulty achieving orgasm | ❑ | ❑ | ❑ | ❑ |
| My opportunity for sexual activity is limited | ❑ | ❑ | ❑ | ❑ |
| My stomach feels like it's bloated or I've gained weight | ❑ | ❑ | ❑ | ❑ |
| I have breast tenderness | ❑ | ❑ | ❑ | ❑ |
| I have joint pains | ❑ | ❑ | ❑ | ❑ |

## Section 14. ABOUT MENOPAUSE AND HORMONE THERAPY

How do you view menopause?

- ❑ **Positively.** For example, menopause means no more periods and no more worry about contraception. Menopause marks a new life phase.
- ❑ **Negatively.** For example, menopause means a loss of fertility and loss of youth.
- ❑ Other:

What concerns you about menopause?

(Please continue on back, if needed.)

What are your current views regarding hormone therapy for menopause?

- ❑ Positive. Hormone therapy is appropriate for some women.
- ❑ Negative. I don't support the use of hormone therapy.

What concerns you most about hormone therapy for menopause?

(Please continue on back, if needed.)

How would you rate your knowledge about menopause?

❑ Very good ❑ Fair ❑ Moderately good ❑ Little knowledge

How do you get your information about menopause? (Mark all that apply.)

❑ Books ❑ Internet ❑ Magazines ❑ Friends ❑ TV ❑ Healthcare providers

Is there anything else you would like your healthcare provider to know?

(Please continue on back, if needed.)

**Thank you! Please note that the information you have provided will be held in the strictest confidence.**

The North American Menopause Society has provided this form as a service to the healthcare community based on the best understanding of the science related to menopause at the time of publication, but the form should be used with the clear understanding that continued research may result in new knowledge and recommendations. This form is provided only as a diagnostic assist to practitioners making clinical decisions regarding the health of women in their care. Its contents provide guidance and, as such, it cannot substitute for the individual judgment brought to each clinical situation by the caregiver with respect to any additional data that may be required in order to make appropriate clinical decisions. The North American Menopause Society is not responsible nor liable for any advice, diagnosis, course of treatment, or drug or device application based on the healthcare provider's use of this form.

FAMILY HISTORY

| Family Members | Status (Living or Deceased) | Year of Birth | Age at Death | Significant Health Concerns | Cause of Death |
|---|---|---|---|---|---|
| Father | | | | | |
| Mother | | | | | |
| Sister 1 | | | | | |
| Sister 2 | | | | | |
| Sister 3 | | | | | |
| Sister 4 | | | | | |
| Sister 5 | | | | | |
| Brother 1 | | | | | |
| Brother 2 | | | | | |
| Brother 3 | | | | | |
| Brother 4 | | | | | |
| Brother 5 | | | | | |
| Paternal Grandfather | | | | | |
| Paternal Grandmother | | | | | |
| Maternal Grandfather | | | | | |
| Maternal Grandmother | | | | | |
| Maternal Aunt | | | | | |
| Paternal Aunt | | | | | |
| Adopted | | | | | |

Holland Hospital

# Patient Information

PLEASE PRINT

Appt. Date/Time: Appt. Dr.: PCP: Account No:

Demographic Information

Last Name: First Name: M.I.:

Address: Date of Birth: Age: Sex:

City, State, Zip:

Social Security No: Marital Status: Maiden/Previous Name:

Home Phone: Work Phone:

Cell Phone: Email:

Employer Name: Employer Address:

Preferred Pharmacy: Address: Phone:

Race: ☐American Indian ☐Asian ☐African American ☐Caucasian ☐Other ☐Do not wish to report

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Do not wish to report

Language:

## Insurance Information

Please give your insurance card(s) to the person at the front desk.

Person responsible for the bill:

Address (if different from patient):

Home Phone: Is this person a patient here? ☐Yes ☐No

Primary Insurance: Subscriber's Name:

Subscriber's Date of Birth: Subscriber's Social Security No:

Policy No.: Group No.:

Patient's Relationship to Subscriber:

Secondary Insurance: Employer:

Subscriber's Date of Birth: Subscriber's SSN:

Policy No.: Group No.:

Patient's Relationship to Subscriber:

## In Case of Emergency

Emergency Contact:

Relationship to Patient: Contact Phone:

Signature: Date: