Calgary Well Women Menopause Clinic
4640 17 Ave NW Calgary AB T3B 0P3
(587)332-6344 or (403) 202-2727

Personal Information

Date: _____
Name: _____
Address: _____
_____

Telephone (Primary): _____ Secondary: _____
Date of Birth(MM/DD/YY): _____ Age: _____

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

Employment (circle): Unemployed Employed Retired Disabled
If employed occupation:

Who is your primary healthcare provider? _____
Location _____
Phone #: _____

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?

_____
_____

Physical Information

Height _____ cm
Weight _____ kg

Medical History;

Medical Problems/Hospitalizations/Past Surgeries: _____
_____
_____
_____

Medications: _____
_____
_____
_____

Have you used any other therapy for menopause (such as acupuncture or yoga)?_____
_____

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): _____

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Gynecologic History con't

Age at first menstrual period: _____
Are/were your periods regular? ☐ Yes ☐ No
Do you have a uterus? ☐ Yes ☐ No ☐ Don't Know
Do you have both ovaries? ☐ 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? ☐ Yes ☐ No
(PMS is having mood swings, bloating, headaches, just prior to your period)

Do you examine your breasts? ☐ Yes ☐ No

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? _____
Bone Density Test: _____

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 (type_____)	☐	☐	Natural family planning/rhythm	☐	☐
Injectable hormone	☐	☐	other	☐	☐

How many times have you been pregnant? _____
How many children do you have? _____

Please provide the number of your:
Full term births: _____
Premature births: _____ Abortions: _____
Miscarriages: _____ Living Children: _____

Any complications during pregnancy, delivery, or postpartum? ☐ Yes ☐ No
If yes, please describe: _____
_____

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Sexual History

Are you currently sexually active? ☐ Yes ☐ No
If yes, are you currently having sex with: ☐ Males ☐ Females ☐ Both
How long have you been with your current sexual 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: ☐ Males ☐ Females ☐ Both
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 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

Allergy Information

Are you allergic to any medications?
If yes please list _____
_____
_____

Family History

Please list family member (ie, mother, father, sister, brother, grandparent, aunt, uncle) who currently has or once had:
Breast Cancer: _____
Osteoporosis _____
Gynecological Cancer: _____

Personal Habits - Tobacco & Alcohol use

Do you currently smoke cigarettes? ☐ Yes ☐ No
If yes, how many per day? _____
How do you feel about quitting smoking? ☐ No Way ☐ Maybe ☐ Absolutely
When did you start? _____
If you do not currently smoke cigarettes, have you ever smoked? ☐ Yes ☐ No
If yes, when did you start? _____
Do you use any other type of tobacco? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No
If yes how many per week? _____

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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 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 leak urine	☐	☐	☐	☐
I have pain or burning when urinating	☐	☐	☐	☐
I have bladder infections	☐	☐	☐	☐
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 stomach feels like it's bloated or I've gained weight	☐	☐	☐	☐
I have breast tenderness	☐	☐	☐	☐
I have joint pains	☐	☐	☐	☐