Arise Menopause & Mental Health

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Menopause Intake Form

Reason for your visit today:

_____

_____

Main concerns or questions regarding your health and menopause:

_____

_____

Main concerns or questions surrounding hormone therapy:

_____

_____

Major Illnesses, hospitalizations or surgeries:

_____

_____

Date/Illness, hospitalization/surgery:

_____

_____

_____

Past Medical History- Do you have a history of any of the following (please circle all that apply):

Migraines	Hepatitis/Liver problems	Arthritis/Back Pain	High Blood Pressure
Gallbladder Problems	Seizures	Stroke	Breast Biopsies
Broken Bones	Elevated Cholesterol	Endometriosis	Dizziness
Blood Clots	Fibroids	Anemia	Infertility
Suicidal thoughts	Indigestion	Cancer	Asthma
Diabetes	Thyroid Problems	Substance Abuse	Depression/Anxiety

Family Medical History- (list family members {mother/father/sister/brother etc.} who have the following):

Colon Cancer:		Heart attack:	
Breast Cancer:		Stroke:	

Ovarian/Uterine Cancer:		Diabetes:	
Osteoporosis:		Blood Clots:	
High Blood Pressure:		Alzheimer's/Dementia:	
Depression:		Hip Fracture:	

Other Family History: _____

OB/GYN History:

Age at first menstrual period: _____ Age at last menstrual period: _____

Are you still having periods: _____ Are they regular: _____ Duration of bleeding: _____

Do you have your: Uterus: _____ Both Ovaries: _____ Cervix: _____

Are you currently sexually active? _____ Any concerns about your sex life? _____

Are you currently using birth control? ____ If yes, what method? _____

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

Age at birth of your first child? _____ Age at birth of your last child? _____

Any complications during pregnancy, delivery, or post-partum? _____

_____

_____

Are you currently using any hormone therapy or menopause supplements? If yes, please list the name, dose, and the frequency below.

_____ _____

_____ _____

_____ _____

_____ _____

Lifestyle:

Do you exercise?_____ How many days per week? _____

What do you do for exercise? _____

_____

_____

Would you describe your diet as: Excellent_____ Good _____ Fair _____ Poor _____

Do you follow any dietary guidelines? _____

_____

Do you drink caffeine (coffee, tea, soda, energy drinks)? _____ Cups per day? _____

Do you smoke (cigarettes, cigars, marijuana, vape)? _____ How much/often? _____

Do you drink alcohol? _____ How many drinks per week? _____

Any recreational drug use? _____

Within the last year, have you been the victim of emotional, physical, or sexual abuse? _____

Do you feel safe in your current living situation? _____

What are your current life stressors or major life changes?

_____

_____

_____

What do you do to deal with your stress or to help you relax?

_____

_____

_____

What do you hope to gain from this office visit today? _____

_____

_____

Height: _____ Weight: _____

Date of your last:

Pap Smear_____ Any abnormal Pap smears?_____

Mammogram: _____ Bone Density Test: _____

Colonoscopy: _____ Blood work: _____

Allergies:

Do you have any allergies to any medications? _____ If so, which?_____

_____

Do you have a peanut allergy? _____

Current Medications:

NAME	DOSE	FREQUENCY

Name: _____ Date: _____