Moreland

Leading Women To Better Health OB-GYN

Date:
Name:
What are your main concerns or questions you would like to have addressed?
How did you hear about this program?
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Committed Relationship
Name of primary support person:
Relationship:
Employment Status: ☐ Unemployed ☐ Employed ☐ Retired ☐ Disabled ☐ Medical Leave If employed, occupation:
Ethnic Background:
How do you feel about aging?

Height and Weight:
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?
What is you usual adult weight?

Medical History
Please check if you have had problems with:

☐ Migraines	☐ Family history of other cancer	☐ Diabetes	☐ Suicidal thoughts
☐ Blood pressure	☐ Colitis	☐ Thyroid disease	☐ Fatigue
☐ Stroke	☐ Diarrhea	☐ Asthma	☐ Difficulty sleeping
☐ High cholesterol	☐ Constipation	☐ Muscle or joint pain	☐ Mood swings
☐ Heart attack	☐ Bloody or black bowel movements	☐ Back pain	☐ Family history of osteoporosis
☐ Chest pain	☐ Hepatitis	☐ Skin changes	☐ Bone density test shows bone loss
☐ Blood clots legs/lungs	☐ Liver problems	☐ Seizures	☐ Height loss
☐ Varicose veins	☐ Gallbladder problems	☐ Change in vision	☐ Frequent falling
☐ Easy bruising	☐ Incontinence (loss of urine or feces)	☐ Macular degeneration	☐ Broken bones/fractures
☐ Anemia	☐ Breast concerns	☐ Cataracts	☐ Hair loss or excessive growth
☐ Indigestion	☐ Endometriosis	☐ Depression	☐ Wight loss or gain
☐ Frequent nausea or vomiting	☐ Fibroids	☐ Anxiety	☐ Change in teeth or gums
☐ History of breast, ovary or uterine cancer	☐ Arthritis	☐ Stress	☐

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 consecutive months without a period)
- ☐ Postmenopause (after menopause)

  Was your menopause:

  - ☐ Spontaneous (natural)
  - ☐ Surgical (removal of both ovaries)
  - ☐ Due to chemotherapy or radiation therapy; reasons for therapy: ____________
  - ☐ Other (explain):____

Age of first menstrual period: ______________________________

Do you have a uterus? ☐ Yes ☐ No ☐ Unsure

Do you have ☐ Both ovaries ☐ One ovary ☐ No ovaries ☐ Unsure

Do you have a cervix? ☐ Yes ☐ No ☐ Unsure

If not still having periods, what was your age of your last period?__________

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

If there is a recent change in how often you have periods? ☐ Yes ☐ No

Is a recent change in how many days do you bleed? ☐ Yes ☐ No

Do you have heavy periods? ☐ Yes ☐ No

Do you have any problems with PMS(mood swings, bloating, headaches prior to your period?

☐ Yes ☐ No

Do you pay attention to your breasts? ☐ Yes ☐ No

Did you mother take DES (used November 1971 and before) when she was pregnant with you?

☐ Yes ☐ No ☐ Don't know

Obstetrical History

Method to Prevent Preganacy (check boxes that apply)

Using Now	Previously used	Type
☐	☐	None
☐	☐	Sterilization (tubes tied)
☐	☐	Male partner, vasectomy, female partner
☐	☐	IUD
☐	☐	Injectable hormone (Depo Provera)
☐	☐	Implanted hormone (Nexplanon or Implanon)
☐	☐	Diaphragm
☐	☐	Foam/gel
☐	☐	Condoms
☐	☐	Birth control pill, ring, skin patch
☐	☐	Natural Family Planning
		Other:___________________

How many times have you been pregnant?	
How old were you when your last child was born?	
How many children do you have?	Do you have adopted children?
Did you place any children up for adoption?	

Please provide the number of:

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

Sexual History

Are you currently sexually active? ☐ Yes ☐ No

If yes, are you currently having sex with ☐ A man (men) ☐ A woman (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 (practicing safe sex) ☐ Yes ☐ No

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

How many lifetime sexual partners have you had?_____________________________________

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 ☐ N/A

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

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

Exercise Habits

Do you consider your health to be:	Excellent ☐	Good ☐		Fair ☐	Poor ☐
How often do you exercise?	Almost Daily ☐	At least 3 days a week ☐	Occasionally ☐	Rarely ☐	Never ☐

If you exercise, what do you do?______________________________________

On average, how long does your exercise session last?____

How long have you been exercising in your life?____

If you are not currently exercising and have followed an exercise program in the past, what did you do?

____

Diet

How many meals do you consume each day? ______

Do you try to eat a special diet? ☐ Low-fat ☐ Low Carb ☐ High Protein ☐ Vegetarian

Other: ______________________

Do you consume dairy products? ☐ Yes, how much? ☐ No

Do you consume calcium fortified foods? ☐ Yes, what kind? ☐ No

Do you eat leafy greens? ☐ Yes, how many a day? ☐ No

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

How many servings of fish do you consume each week?_______

Do you eat fruit every day? ☐ Yes, how many servings a day? ☐ No

Do you eat vegetables every day? ☐ Yes, how many servings a day? ☐ No

Do you drink soda? ☐ Yes ☐ No What kind?

Tobacco use
Do you currently smoke cigarettes? ☐ Yes ☐ No If yes, how many per day? ____ If no, have you ever smoked? ______ What age did you start smoking? ______ When did you quit smoking? ______ Do you use any other type of tobacco? ☐ Yes ☐ No Type? ______________ Do you use any non-nicotine products (vape/e-cig, chew, etc.) ☐ Yes ☐ No What type? Do you use marijuana or consume edible marijuana? ☐ Yes ☐ No

Sleep Habits
On average, how many hours do you sleep per night?
Do you have any struggles with sleep? ☐ Yes ☐ No If yes, list struggles:
Do you take any sleep aids? ☐ Yes ☐ No If yes, what kind:

Caffeine Use
Do you consume drinks with caffeine (coffee, tea, juice)? ☐ Yes ☐ No If yes, how many drinks a day? _____

Alcohol and drug use		
Do you drink alcohol? If yes, how many drinks a week?	☐ Yes	☐ No
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 struggled with drugs or alcohol abuse?	☐ Yes	☐ No
Do you use recreational 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 a sexual activity?	☐ Yes	☐ No
Do you feel you are verbally or emotionally abused by someone?	☐ Yes	☐ No
Have you had counseling for these issues?	☐ Yes	☐ No
Do you feel safe in your home?	☐ Yes	☐ No

Symptoms- Please indicate how bothered you are now and in the recent past by any of the following:				
Problem	Not at all	A little bit	Quite a bit	Extremely
Hot flashes	☐	☐	☐	☐
Night sweats	☐	☐	☐	☐
Heart palpitations or a sensation of butterflies in chest or stomach	☐	☐	☐	☐
Feel like skin is crawling or itching	☐	☐	☐	☐
Feel more tired than usual	☐	☐	☐	☐
Difficulty concentrating	☐	☐	☐	☐
Memory is poor	☐	☐	☐	☐
Increased irritability	☐	☐	☐	☐
Increased anxiety	☐	☐	☐	☐
Depressed mood	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐
Crying spells	☐	☐	☐	☐
Headaches	☐	☐	☐	☐
Urinate more often than usual	☐	☐	☐	☐
Urine leakage	☐	☐	☐	☐
Pain or burning when urinating	☐	☐	☐	☐
Frequent bladder infections	☐	☐	☐	☐
Loss of stool or gas	☐	☐	☐	☐
Vaginal dryness	☐	☐	☐	☐
Vaginal itching	☐	☐	☐	☐
Vaginal discharge	☐	☐	☐	☐
Vaginal infections	☐	☐	☐	☐
Bleeding after sex	☐	☐	☐	☐
My opportunity for sexual activity is limited	☐	☐	☐	☐
Stomach bloat, or feeling of weight gain	☐	☐	☐	☐
Breast tenderness	☐	☐	☐	☐
New joint pain	☐	☐	☐	☐
Past traumatic pelvic exam	☐	☐	☐	☐

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? ____

Menopause and Hormone Therapy
How do you view menopause? ☐ Positively. Menopause means no more periods and no more worry about contraception. Menopause marks a new life for me. ☐ Negatively. For example, menopause means a loss of fertility and loss of youth. ☐ Other:
What are your views about hormone therapy? ☐ Positive. Hormone therapy is appropriate for some women. ☐ Negative. I don't support the use of hormone therapy. ☐ Other:
What concerns you about hormone therapy for menopause:______________________________________ ____ ____
What concerns you most about hormone therapy for menopause? _________________ ____ ____ ____ How would you rate your knowledge about menopause? ☐ Very good ☐ Fair ☐ Moderately good ☐ Little knowledge
How did you get your information about menopause? (Mark all that apply) ☐ Books ☐ Internet ☐ Magazines ☐ Friends ☐ TV ☐ Healthcare providers ☐ Other
Is there anything else you would like your healthcare provider to know?