Menopause Center of Minnesota

DOS ___________________________

Name: ____ **Age:** _____________ **DOB:** ______________________

Reason for today's appointment: ____

Vitals: BP: ___________________ **Wt:** ____________________ **Ht:** ____________________ **BMI:** __________________

Primary care provider: ____

Date of last mammogram: _____________________________ **Date of last Pap smear:** ______________________________

Are you up to date on immunizations? (Circle one) Yes / No

Date of last bone density test & result: ____

Date of last colonoscopy: ____

Lifestyle Behaviors:

1. Exercise: Type: ____________________________________ # of Days/Week ___________ for ___________ minutes
2. Occupation: ____
3. Drugs: Please list below or attach a separate sheet
   Hormones ____
   ____
   All other prescription medications ____
   ____
   Vitamins/Minerals/Diet supplements ____
   ____
   Herbals ____
   ____
4. Self-Breast Exam? (Circle one) Yes / No If Yes, how often? ____
5. Kegel's Exercise (vaginal tightening): (Circle one) Yes / No If yes, how often? _______________________________
6. Cigarette smoking? (Circle one) Yes / No If Yes: # per day _____________ Since age _________________________
7. Alcohol use: (Check one) Daily _____ Weekly _____ Monthly _____ None _____
8. Caffeine use: Cups per day ___________________
9. Are you having menstrual periods? (Circle one) Yes / No Date of last period: ______________________________
   Check all that apply: Are they regular? _______ Irregular? _______ Variable? _______Heavy? _______ Pass large clots? _______
10. What is your current method of birth control? ____
11. Have you had a hysterectomy? Yes / No If Yes, reason: ___________________________________ Year: __________
12. Surgeries: Operation and year ____
13. Allergies: ____

Past Medical History: Check all that apply to you or family members (parents, grandparents, siblings)

Conditions	Self	Family	Details
High blood pressure			
Uterine fibroids			
Endometriosis			
Thyroid disease			
Liver disease			
Cancer, specify type			
Seizures			
Migraines			
Heart disease, at what age			
Blood clots in legs/lungs			
Stroke			
Gallbladder disease			
Fibrocystic breasts			
Abnormal mammogram			
Osteoporosis/osteopenia			
High cholesterol			
Diabetes			
Alzheimer's			

DOS ___________________________

Name: ____ DOB: ____________________________

Review of Systems	
Constitution:	Integumentary/Skin:
Eye:	Neurological:
ENT/Mouth:	Psychological:
Heart:	Endocrine:
Respiratory:	Allergy/Immuno:
Gastro Intestinal:	All Other Negative:
Genital/Urinary:	
Muscular:	

Symptoms		
Please check all of the symptoms that you are currently experiencing:		
Condition	√	Comments
Fatigue/insomnia		
Weight gain/struggle to maintain		
Depression/low mood		
Irritability		
Mood swings		
Anxiety		
Loss of urine control		
Poor memory/fuzzy thinking		
Hot flashes/night sweats		
Vaginal dryness		
Restless, jumpy legs		
Lack of, or change of, interest in sex		
Discomfort/pain with intercourse		
Painful breasts		
Heart palpitations		
Fear of being alone in public		
Negative response to being touched		
Dry skin/hair/nails		
Headache/migraine		
Hair thinning/loss		

For Providers Use:

Notes:
Dx:
Plan:
EM Code:
Provider Signature: