



**Women's Midlife Health Program  
Initial Appointment Form**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Referred by: \_\_\_\_\_ Your Occupation \_\_\_\_\_ Date: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Who do you live with? \_\_\_\_\_

Primary Care MD/Provider (& other pertinent care providers): \_\_\_\_\_

Allergies: \_\_\_\_\_

List (and bring) Current Prescription Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List (and bring) Supplements/Frequently used Over-the-Counter Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What was the date of your last menstrual cycle? \_\_\_\_\_

What symptom is bothering you the most today? \_\_\_\_\_

What is your expected outcome from your visit today? \_\_\_\_\_

**Past Medical History - Have you ever been diagnosed with:**

| <b>Please check</b>          | <b>No</b> | <b>Yes – When?</b> |                             | <b>No</b> | <b>Yes – When?</b> |
|------------------------------|-----------|--------------------|-----------------------------|-----------|--------------------|
| Breast Cancer                |           |                    | Psychiatric Illness         |           |                    |
| Other Type of Cancer         |           |                    | Depression /Anxiety         |           |                    |
| Diabetes                     |           |                    | Alcoholism/ Drug Abuse      |           |                    |
| High Cholesterol             |           |                    | Autoimmune Disease          |           |                    |
| High Blood Pressure          |           |                    | Arthritis/Joint Pain        |           |                    |
| Alzheimer's                  |           |                    | Kidney or Bladder Disease   |           |                    |
| Stroke                       |           |                    | Ulcer/IBS Syndrome          |           |                    |
| Heart Disease/Murmur         |           |                    | Liver/Gallbladder Disease   |           |                    |
| Sleep Apnea                  |           |                    | Sinus Problems              |           |                    |
| Osteoporosis/Osteopenia      |           |                    | Lung Disease/Asthma         |           |                    |
| Blood Clot/Bleeding Disorder |           |                    | Chronic Pain - Fibromyalgia |           |                    |
| Thyroid Problems             |           |                    | Neurological Problems       |           |                    |
| Migraines/Headaches          |           |                    | Skin Problems               |           |                    |
| Epilepsy/Seizures            |           |                    | Eating Disorder             |           |                    |
| Breast Lump                  |           |                    | Other:                      |           |                    |

Please list any hospitalizations and surgeries you have had (excluding normal vaginal deliveries):

\_\_\_\_\_

\_\_\_\_\_

## Symptom Severity History

Please note the severity of any symptoms you may have experienced over the past **4 weeks**:

| All bolded symptoms below may be related to hormone imbalances. | None | Mild | Moderate | Severe | Comments |
|---|------|------|----------|--------|----------|
| <b>Fatigue/tired and/or exhausted</b>                           |      |      |          |        |          |
| <b>Food cravings – carbs/salty/sweets</b>                       |      |      |          |        |          |
| <b>Trouble controlling urine/leaking</b>                        |      |      |          |        |          |
| <b>Lack of energy/endurance</b>                                 |      |      |          |        |          |
| <b>Depression</b>   |      |      |          |        |          |
| <b>Headaches or migraines</b>                                   |      |      |          |        |          |
| <b>Rapid changes in mood/mood swings</b>                        |      |      |          |        |          |
| <b>Lack of sex drive/libido/sexual desire</b>                   |      |      |          |        |          |
| <b>Bloating/water retention</b>                                 |      |      |          |        |          |
| <b>Difficulty falling and staying asleep</b>                    |      |      |          |        |          |
| <b>Memory problems/forgetfulness</b>                            |      |      |          |        |          |
| <b>Acne/oily skin</b>   |      |      |          |        |          |
| <b>Increased anxiety</b>  |      |      |          |        |          |
| <b>Increased irritability and/or anger</b>                      |      |      |          |        |          |
| <b>Hair is thinning/hair loss</b>                               |      |      |          |        |          |
| <b>Increased growth of facial hair</b>                          |      |      |          |        |          |
| <b>Breasts tender/sore and/or swollen</b>                       |      |      |          |        |          |
| <b>Vaginal dryness, pain or itching</b>                         |      |      |          |        |          |
| <b>Hot flashes/night sweats</b>                                 |      |      |          |        |          |
| <b>Trouble thinking and/or foggy thinking</b>                   |      |      |          |        |          |
| <b>Decreased motivation</b>                                     |      |      |          |        |          |
| <b>Decreased sexual arousal and pleasure</b>                    |      |      |          |        |          |
| <b>Muscle weakness and/or loss of strength</b>                  |      |      |          |        |          |
| <b>Decreased focus or attention span</b>                        |      |      |          |        |          |
| <b>Feeling fearful/afraid for no reason</b>                     |      |      |          |        |          |
| <b>Loss of skin tone and/or wrinkles</b>                        |      |      |          |        |          |
| <b>Breasts less full and/or sagging</b>                         |      |      |          |        |          |
| <b>Weight loss</b>  |      |      |          |        |          |
| <b>Weight gain</b>  |      |      |          |        |          |
| <b>Low back and/or joint pain</b>                               |      |      |          |        |          |
| <b>Increased hostility/aggression</b>                           |      |      |          |        |          |
| <b>Dry skin</b>   |      |      |          |        |          |
| <b>Warm and/or flushed skin</b>                                 |      |      |          |        |          |
| <b>Brittle nails</b>  |      |      |          |        |          |
| <b>Unable to tolerate cold</b>                                  |      |      |          |        |          |
| <b>Heavy and/or irregular periods</b>                           |      |      |          |        |          |
| <b>Nervousness</b>  |      |      |          |        |          |
| <b>Excess sweating</b>  |      |      |          |        |          |
| <b>Rapid, pounding and/or irregular heartbeat</b>               |      |      |          |        |          |
| <b>Dry Eyes</b>   |      |      |          |        |          |
| <b>Hay fever/allergies</b>                                      |      |      |          |        |          |
| <b>Frequent infections/persistent cough</b>                     |      |      |          |        |          |
| <b>Frequent constipation/diarrhea</b>                           |      |      |          |        |          |
| <b>Hemorrhoids</b>  |      |      |          |        |          |
| <b>Breast Lump or nipple discharge</b>                          |      |      |          |        |          |

### Gynecologic & Obstetrics History

|  |        |
|--|--------|
| <b>Please fill in the blank or circle Yes or No:</b>   |        |
| # of Pregnancies _____ # of Live Births _____ Ages of children now: _____                              |        |
| Age at first period: _____ Number of menstrual cycles in past year: _____                              |        |
| Have you had your ovaries removed? No Yes If so why: _____   |        |
| Have you had your uterus removed? No Yes If so why: _____  |        |
| How many days do you flow? _____ Average # of days between periods: _____                              |        |
| # of menses in past year: _____ Any changes in menses? _____   |        |
| Could you be pregnant now?   | No Yes |
| Do/did you have significant pain with your periods:  | No Yes |
| Do you have any spotting or bleeding between periods?  | No Yes |
| Do you have a history of abnormal pap smears?  | No Yes |
| Have you been exposed to DES (a drug your mom took when pregnant w/ you)?                              | No Yes |
| Do/did you have any infertility issues?  | No Yes |
| Have you had any reproductive issues (ovarian cysts, D & C, fibroids, endometriosis)?                  | No Yes |
| Did you have any complications with pregnancy or delivery?   | No Yes |
| What is your sexual orientation? (circle) Straight Bisexual Lesbian                                    |        |
| Current number of sexual partners: _____   |        |
| List any sexually transmitted diseases you have had: _____   |        |
| List current form of birth control: _____  |        |
| Have you ever taken birth control pills? No Yes If so when? _____                                      |        |
| Have you suffered from any form (physical, emotional, sexual) of abuse?                                | No Yes |
| Are you having any issues with sexual desire, arousal, orgasm or pain?                                 | No Yes |
| Are you satisfied with your sexual function over the past 3 months?                                    | Yes No |
| Please list hormone replacement medications and herbal products used to relieve your hormone symptoms: |        |
|  |        |

### Family History (Please note the approximate age when the condition was diagnosed)

|                      | None | Mother | Father | Siblings | Mother's Parents | Father's Parents | Others |
|----------------------|------|--------|--------|----------|------------------|------------------|--------|
| Osteoporosis         |      |        |        |          |                  |                  |        |
| Alzheimer's          |      |        |        |          |                  |                  |        |
| Breast Cancer        |      |        |        |          |                  |                  |        |
| Other Cancer         |      |        |        |          |                  |                  |        |
| Heart Disease        |      |        |        |          |                  |                  |        |
| Hypertension         |      |        |        |          |                  |                  |        |
| Stroke               |      |        |        |          |                  |                  |        |
| Blood Clots          |      |        |        |          |                  |                  |        |
| Diabetes             |      |        |        |          |                  |                  |        |
| Thyroid Disorder     |      |        |        |          |                  |                  |        |
| Mental Illness       |      |        |        |          |                  |                  |        |
| Alcohol/drug abuse   |      |        |        |          |                  |                  |        |
| Menopausal Issues    |      |        |        |          |                  |                  |        |
| Other:               |      |        |        |          |                  |                  |        |
| Deceased @ age/cause |      |        |        |          |                  |                  |        |

### Self Care

| Please check Agree or Disagree  | Agree | Disagree | Comments |
|---|-------|----------|----------|
| I take a daily pharmacy or USP grade multi-vitamin and mineral supplement at least two times per day.                                     |       |          |          |
| I consume at least 1000 mg. of Calcium, 500 mg. of Magnesium and 1000 I.U. of Vitamin D(3) daily (considering both diet and supplements). |       |          |          |
| I take at least 1000mg of EPA/DHA in the form of Fish oil daily.  |       |          |          |
| I use deep breathing exercises or other forms of stress management to help me stay calm when needed.                                      |       |          |          |
| I practice at least 2 hours of relaxation per week.   |       |          |          |
| I exercise at least 4 times weekly for a minimum of 30-40 minutes each.   |       |          |          |
| I drink 64 ounces of water daily.   |       |          |          |
| I eat 3 regular meals and 3 snacks daily.   |       |          |          |
| I eat protein with every meal or snack.   |       |          |          |
| I eat whole grains, beans and legumes daily.  |       |          |          |
| I eat at least seven (½ ) cup servings of fruits and vegetables daily.  |       |          |          |
| I minimize simple carbohydrates (candy, cookies, soda etc.) daily.  |       |          |          |
| I consume at least 25 grams of fiber daily.   |       |          |          |
| I consume one or less serving of caffeine daily.  |       |          |          |
| I drink 2 or less servings of alcohol per week.   |       |          |          |
| I do not smoke now and never have smoked.   |       |          |          |
| I do not use street drugs.  |       |          |          |
| My work and personal life are not stressful.  |       |          |          |
| I do not feel overcommitted or rushed.  |       |          |          |
| I do not experience much stress in my relationships.  |       |          |          |
| I have a good support network of family and friends.  |       |          |          |
| I receive support through my spiritual or religious beliefs and practices.  |       |          |          |
| I have not experienced any major losses or traumas recently.  |       |          |          |
| Do you use sleep aids:  | No    | Yes      |          |
| Average # of hours of sleep per night: _____ Feel rested daily:   | No    | Yes      |          |

### Preventative Health Care Screenings

| The Date and Location of your last: | Was your result normal? | Comments |
|-------------------------------------|-------------------------|----------|
| Gynecological Exam:                 | YES NO                  |          |
| Pap smear:                          | YES NO                  |          |
| Mammogram:                          | YES NO                  |          |
| Thyroid test:                       | YES NO                  |          |
| Cholesterol test:                   | YES NO                  |          |
| Bone density test:                  | YES NO                  |          |
| Colorectal cancer test:             | YES NO                  |          |

I have reviewed (and updated where needed) the above form and the information is correct.

Patient Signature/date:

Provider Signature/date:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_