

Patient label

Age

Date.....

Menopause Clinic History Sheet

Menstrual History		Obstetric History	
LMP Cycle Loss		Gravida.....Para..... Problems	
Cervical smear		Mammogram	Contraception
Date..... Result		Date..... Result	
Gynae History			
90149014			
Gynae Problems	No	Yes	Comment
Gynae Surgery	No	Yes	Comment
Urinary History			
Recurrent UTIs Bladder problems Investigations Surgery	No	Yes	Comment

Patients Medical History

	No	Yes	Comments
Diabetes			
Thyroid			
Heart disease			
Hypertension			
Renal			
Liver			
Varicose Veins			
Thrombosis			
Malignant disease			
Other medical conditions			
Psychiatric history			
Osteoporosis			
Previous Fractures			
BMD			
Non Gynae surgery			

Medication	HRT
	Present
	Previous

Allergies

Family History				
	No	Yes	Family Member	Age
Early Menopause				
Heart disease / stroke				
Hypertension				
Thromboembolic disease				
Osteoporosis				
Diabetes				
	No	Yes	Family Member	Age
Cancer				
Breast				
Ovarian				
Bowel				
Social History				
	No	Yes	Comments	
Current relationship				
Employment				
Stresses				
Exercise				
Smoking				
Alcohol				
Recreational drug use				

Examination			
Weight Height 0 Blood Pressure <div style="text-align: center; margin-top: 20px;">BMI</div>	Vaginal Pelvic Breast		
Discussion			
	No	Yes	Comments
Menopausal symptoms HRT options Risks DVT Breast cancer Stroke Ovarian Cancer Benefits Symptom control Osteoporosis Pts preferred option Sample shown Instructed on use Transient side-effects Possible problems Alternatives to HRT Life style			
Further Information			
Help line number <input type="checkbox"/> Email address <input type="checkbox"/> "Finding the right information" Other <input type="checkbox"/>			
Patients Email			
Consent to contact - Signature.....			

History taken by:-

Name.....Designation.....

Signature.....Date & Time.....