

THIS INFORMATION IS PROVIDED FOR OUR PATIENTS ONLY.

**The Perimenopause/Menopause Patient
Assessment of Potential Risk Factors**

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Patient: _____ **Age:** _____ **Date:** _____

Reason for consultation: _____

1. Are you experiencing:

2.

- a. ___ A change in the amount or duration of her menstrual flow? If yes, how long? _____
- b. ___ A change in the length of her menstrual cycles? If yes, how long? _____
 ___ Shortening ___ Lengthening ___ Irregularly irregular
- c. ___ Hot flashes? _____ Number/week
- d. ___ Sweating at night? _____ Number/week
- e. ___ Vaginal dryness, frequent UTIs, or discomfort with sexual intimacy? How long? _____
- f. ___ Insomnia and sleep disturbances? How long? _____
- g. ___ Forgetfulness? How long? _____
- h. ___ Mood swings? How long? _____
- i. ___ Urine leakage? Is it caused by coughing or exercise? ___ Yes ___ No
- j. ___ Palpitations? How long? _____

3. Do you have any of the following risk factors:

4.

Cardiovascular Disease

- a. ___ Current smoker
- b. ___ Hypertension (high blood pressure)
- c. ___ Diabetes mellitus
- d. ___ Insulin resistance
- e. ___ Lipid abnormalities (HDL < 35 mg/dL or LDL > 160 mg/dL)
- f. ___ + Family history of premature Heart Disease Who _____
- g. ___ + Past history of peripheral atherosclerosis or coronary heart disease (CHD)
- h. ___ + Past history of thromboembolic disease

Osteoporosis

- a. ___ Small frame (< 127 lbs)
- b. ___ Onset of early menopause (<40)
- c. ___ Low calcium intake most of life
- d. ___ Excessive alcohol
- e. ___ Minimal physical activity
- f. ___ Use of steroids
- g. ___ Use of thyroid supplementation
- h. ___ + Past history of a fracture as an adult

- i. ___ + Family history of osteoporosis (thinning of bones) Who _____
- j. ___ + Family history of fracture in first-degree relative Who _____

Breast Cancer

- a. ___ + Past history of Breast cancer, when _____ Type of cancer _____
- b. ___ + Family history of Breast cancer Who _____
- c. ___ + Past history of Mammogram results = "Dense Breast Tissue"
- d. ___ + Past history of Bone Density results = "High Bone Density"

Macular Degeneration

- a. ___ Impaired eyesight
- b. ___ + Family history of reduced vision in old age Who _____

Other

- a. ___ + Family history of Alzheimer's disease Who _____
- b. ___ + Family history of Colon cancer Who _____

5. What Major Concerns to the use of HRT do you have:

- a. ___ Fear of causation of breast cancer
- b. ___ Fear of uterine cancer
- c. ___ Fear of bleeding
- d. ___ Fear of weight gain/obesity
- e. ___ Fear of unknown side effects
- f. ___ Fear of deep vein thrombosis
- g. ___ Fear of gallbladder disturbance
- h. ___ Fear of untoward alteration of lipid profile
- i. ___ Desire to take "natural" alternatives
- j. ___ Other _____

6. Therapies you have ever tried before consultation:

- a. ___ Estrogen Type _____ Length _____ Effect _____
- b. ___ E/P combination Type _____ Length _____ Effect _____
- c. ___ Oral contraceptives Type _____ Length _____ Effect _____
- d. ___ Natural supplements Type _____ Length _____ Effect _____
- e. ___ Anti-resorptive agents Type _____ Length _____ Effect _____
- f. ___ Nothing
- g. ___ Other Type _____ Length _____ Effect _____

**7. Your understanding of the perimenopausal/menopausal issues?
 ___ None ___ Limited ___ Good ___ Well read on subject**

Thank you. ☺

For Physician Use:

Impression: _____

Plan: _____