

Date _____

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____

Circle One: Mr. Mrs. Ms. Nickname _____

Date of Birth: ____/____/____ Birthplace _____ Circle One: Male Female

Home Phone _____ Cell Phone _____ Work Phone _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

E-mail Address: _____ Social Security No. _____

Person Responsible for Payment _____ Relationship to Patient: _____

Address _____ Phone _____

Signature _____

Note: We do not submit insurance. Out-of-pocket costs include clinic consultations, infusion clinic services and testing.

Employer _____ Occupation _____

Employer Address _____

Emergency Contact _____ Phone _____

Education: Years in High School _____ Years in College _____ Years Post-Grad _____

Marital Status (circle one): Single Married Divorced Widowed

Weight: Now _____ One year ago _____ Maximum _____ When _____

Height: _____ feet _____ inches

Primary Care Doctor _____ Date of last physical exam _____

Phone _____

Address _____

E-mail _____

Pharmacy Name _____ Phone _____

Reason for Visit _____

Referred by: Physician (name): _____

Friend or family member (name): _____

Other (please specify): _____

Please check the color that best describes your hair:

Brown Black Blonde Red White Grey Bald

Please check the color that best describes your eyes:

Blue Brown Green Grey Hazel

Please check which best describes your handedness:

Right-handed Left-handed Ambidextrous

Please check the body type that best describes yours.

Ectomorph (slim, thinner body type) Endomorph (rounder, plump body type) Mesomorph (thicker, muscular body type)

Please rank your most troubling symptoms by level of concern to you.

PROBLEM	ONSET	FRQUENCY	SEVERITY
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

What diagnosis or explanations have been given in the past?

What do you hope to achieve in your visit with us? _____

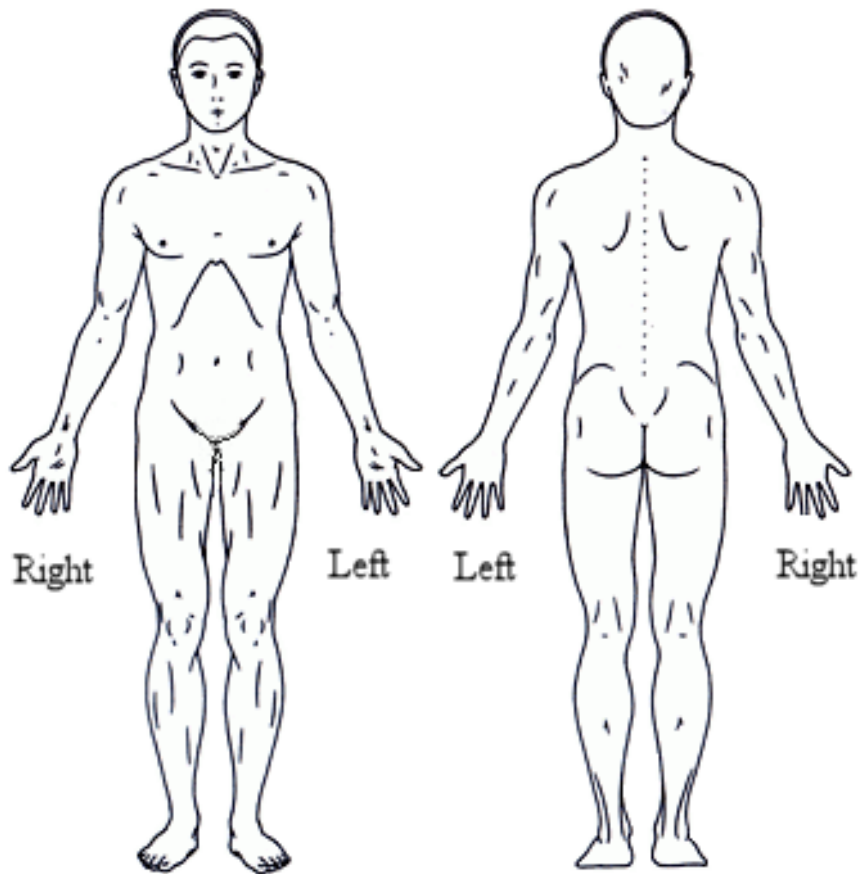
When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel worse? _____

What makes you feel better? _____

Please mark the location(s) of your pain with an "X" on the diagram below. If whole areas are painful, shade in entire area.



How often do you have your pain?

- Constantly (100% of the time)
- Nearly constantly (60-90% of the time)
- Intermittently (30-60% of the time)
- Occasionally (less than 30% of the time)

Please list the dates of the following operations, illnesses, etc. below.

<p>OPERATIONS:</p> <p>Tonsillectomy _____ Appendectomy _____</p> <p>Hysterectomy _____ Hernia _____</p> <p>Gall Bladder _____ P.E. Tubes in ears _____</p> <p>1st Dental Filling _____ 1st Root Canal _____</p> <p>Other Surgeries (<i>and dates</i>): _____</p> <p>_____</p> <p>_____</p>	<p>DIAGNOSTIC STUDIES:</p> <p>When have you had a(n):</p> <p>Chest X-ray _____</p> <p>Mammogram _____</p> <p>EKG _____</p> <p>Sigmoidoscopy _____</p> <p>Colonoscopy _____</p> <p>Upper GI Series _____</p> <p>Barium Enema _____</p> <p>MRI of Brain _____</p> <p>MRI of Abdomen _____</p> <p>MRI of Spine _____</p> <p>Liver Scan _____</p> <p>Bone Scan _____</p> <p>Neck X-ray _____</p>
<p>ILLNESSES:</p> <p>Chicken Pox _____ Mononucleosis _____</p> <p>Measles _____ German Measles _____</p> <p>Mumps _____ Hepatitis _____</p> <p>Other (<i>and dates</i>): _____</p> <p>_____</p> <p>_____</p>	<p>IMMUNIZATIONS:</p> <p>Pneumovax _____</p> <p>Hepatitis Vaccination _____</p> <p>Flu _____</p> <p>Completed Childhood Vaccines:</p> <p>_____</p> <p>Last Tetanus Booster _____</p>
<p>INJURIES:</p> <p>Head Injury _____ Broken _____</p> <p>Neck Injury _____ Broken _____</p> <p>Back Injury _____ Broken _____</p> <p>Other (<i>and dates</i>): _____</p> <p>_____</p> <p>_____</p>	

Please indicate any personal history below.

CONSTITUTIONAL SYMPTOMS

Good general health lately.....Yes No
 Recent weight change.....Yes No
 Decreased appetite.....Yes No
 Fever/night sweats.....Yes No
 Fatigue/weakness.....Yes No
 Headaches.....Yes No

EYES

Eye disease or injury.....Yes No
 Wear glasses/contact lenses.....Yes No
 Blurred or double vision.....Yes No
 Glaucoma/cataracts.....Yes No

EARS/NOSE/THROAT

Hearing loss or ringing.....Yes No
 Earaches or drainage.....Yes No
 Chronic sinus problems.....Yes No
 Nose bleeds.....Yes No
 Mouth sores.....Yes No
 Sore throat or voice change.....Yes No
 Swollen glands in neck.....Yes No

CARDIOVASCULAR

Heart trouble.....Yes No
 Chest pain or angina pectoris.....Yes No
 Palpitation.....Yes No
 Shortness of breath walking or lying...Yes No
 Swelling of feet, ankles, or hands.....Yes No

RESPIRATORY

Chronic or frequent coughs.....Yes No
 Spitting up blood.....Yes No
 Shortness of breath.....Yes No
 Asthma or wheezing.....Yes No

INTEGUMENTARY (skin, breast)

Rash or itching.....Yes No
 Change in skin color.....Yes No
 Change in hair or nails.....Yes No
 Varicose veins.....Yes No
 Breast pain.....Yes No
 Breast lump.....Yes No
 Breast discharge.....Yes No

NEUROLOGICAL

Frequent or recurring headaches.....Yes No
 Light headed or dizzy.....Yes No
 Convulsions or seizures.....Yes No
 Shakes.....Yes No
 Paralysis.....Yes No
 Stroke.....Yes No
 Head injury.....Yes No

PSYCHIATRIC

Memory loss or confusion.....Yes No
 Nervousness.....Yes No
 Depression.....Yes No
 Difficulty sleeping.....Yes No

GASTROINTESTINAL

Loss of appetite.....Yes No
 Change in bowel movement.....Yes No
 Nausea or vomiting.....Yes No
 Frequent diarrhea.....Yes No
 Painful bowel movements or constipation...Yes No
 Rectal bleed or blood in stool.....Yes No
 Abdominal pain.....Yes No
 Ulcer (stomach or duodenal).....Yes No

GENITOURINARY

Frequent urination.....Yes No
 Burning or painful urination.....Yes No
 Awaken at night to urinate.....Yes No
 Blood in urine.....Yes No
 Change in force of stream when urinating....Yes No
 Incontinence or dribbling.....Yes No
 Sores or discharge.....Yes No
 Kidney stones.....Yes No
 Sexual difficulty.....Yes No
 Male testicular pain/lumps.....Yes No
 Female – pain with periods.....Yes No
 Female – irregular periods.....Yes No
 Female – vaginal discharge.....Yes No
 Female – # of pregnancies.....Yes No
 Female – # of miscarriages.....Yes No
 Female – date of last pap smear:_____

MUSCULOSKELETAL

Joint pain.....Yes No
 Joint stiffness or swelling.....Yes No
 Weakness of muscles or joints.....Yes No
 Muscle pain or cramps.....Yes No
 Back pain.....Yes No
 Difficulty in walking.....Yes No

ENDOCRINE

Glandular or hormone problem.....Yes No
 Thyroid disease.....Yes No
 Diabetes (*insulin or non insulin – circle one*)..Yes No
 Excessive thirst or urination.....Yes No
 Heat or cold intolerance.....Yes No

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts.....Yes No
 Bleeding or bruising tendency.....Yes No
 Anemia.....Yes No
 Blood clots.....Yes No
 Blood transfusion.....Yes No
 Enlarged glands.....Yes No

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:
 Penicillin or other antibiotics.....Yes No
 Morphine, Demerol, or other narcotics.....Yes No
 Novocain or other anesthetics.....Yes No
 Aspirin or other pain remedies.....Yes No
 Tetanus antitoxin or other serums.....Yes No
 Iodine, Merthiolate or other antiseptic.....Yes No

ALLERGIC/IMMUNOLOGIC (continued)

Other drugs/medications:

Known food allergies:

Environmental allergies:

Excessive exposure at home or work to:

- Fumes?.....Yes No
- Dust?.....Yes No
- Solvents?.....Yes No
- Air borne particulates?.....Yes No

Others:

SOCIAL HISTORY

- Use of alcohol: Never On occasion Moderately Daily
- Use of tobacco: Never Previously, but quit Currently smoking – packs/day _____
- Use of drugs: Never Type/frequency: _____

NUTRITION HISTORY

- Have you ever had a nutrition consultation? Yes No
- Have you made any changes in your eating habits because of your health? Yes No
- If yes, describe: _____

Check all that apply:

- Low fat Low Carbohydrate High Protein Low Sodium Diabetic
- No Wheat Gluten Restricted Vegetarian Vegan Ultrametabolism
- Specific Program for Weight Loss/Maintenance Type: _____ Other: _____

- Height (feet/inches): _____ Current Weight: _____
- Usual Weight Range +/- 5 lbs: _____ Desired Weight Range +/- 5lbs: _____
- Highest adult weight: _____ Lowest adult weight: _____
- Weight Fluctuations (greater than 10 lbs): Yes No Body Fat %: _____
- How often do you weigh yourself? Daily Weekly Monthly Rarely Never
- Have you ever had your metabolism (resting metabolic rate) checked? No Yes If yes, what was it? _____
- Do you avoid any particular foods? No Yes If yes, types and reason: _____

If you could only eat a few foods a week, what would they be? _____

Do you grocery shop? Yes No If no, who does the shopping? _____

Do you read food labels? Yes No

Do you cook? Yes No If no, who does the cooking? _____

How many meals do you eat out per week? 0-1 1-3 3-5 More than 5

Check all the factors that apply to your current lifestyle and eating habits:

- Fast eater
- Eat too much
- Late night eating
- Dislike healthy food
- Time constraints
- Eat more than 50% of meals away from home
- Travel frequently
- Non-availability of healthy foods
- Do no plan meals or menus
- Reliance on convenience items
- Poor snack choices
- Family members don't like healthy foods
- Love to eat
- Eat because I have to
- Have a negative relationship to food
- Struggle with eating issues
- Emotional eater (eat when sad, lonely, depressed, bored)
- Eat too much under stress
- Eat too little under stress
- Don't care to cook
- Eating in the middle of the night
- Confused about nutrition advice
- Erratic eating pattern
- Family members have special dietary needs or preferences

The most important thing I should change about my diet to improve my health is:

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? Yes No

Are you happy? Yes No

Do you feel your life has meaning and purpose? Yes No

Do you believe stress is presently reducing the quality of your life? Yes No

Do you like the work you do? Yes No

Have you experienced major losses in your life? Yes No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? Yes No

Would you describe your experience as a child in your family as happy and secure? Yes No

STRESS/COPING

Have you ever sought counseling? Yes No

Are you currently in therapy? Yes No If yes, describe: _____

Do you feel you have an excessive amount of stress in your life? Yes No

Do you feel you can easily handle the stress in your life? Yes No

Daily stressors: Rate on a scale of 1 – 10 (1 being the least stress and 10 being the most stress)

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Do you practice meditation or relaxation techniques? Yes No If yes, how often? _____

Check all that apply:

Yoga Meditation Imagery Breathing Tai Chi Prayer Other: _____

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes No

SLEEP/REST

Average number of hours you sleep per night: _____

Do you have trouble falling asleep? Yes No

Do you feel rested upon awakening? Yes No

Do you have problems with insomnia? Yes No

Do you snore? Yes No Sometimes

Do you use sleeping aids? Yes No If yes, explain: _____

ROLES/RELATIONSHIPS

Marital Status: Single Married Divorced Gay/Lesbian Long Term Partnership

List Children:

Child's Name	Age	Gender

Who is living in your household? Number: _____ Names: _____

Their occupation: _____

Check all that apply: Spouse Family Friends Religious/Spiritual Pets

Are you satisfied with your sex life? Yes No

Please mark with an "X" what best describes you.

How well have things been going for you?	Does Not Apply	Poor (1)	Mediocre (2)	Fine (3)	Good (4)	Excellent (5)
Overall						
At school						
In your job						
In your social life						
With close friends						
With sex						
With your attitude						
With your boyfriend/girlfriend						
With your children						
With your parents						
With your spouse						

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? Yes No If yes, describe symptoms: _____

Do you have an adverse reaction to caffeine? Yes No

When you drink caffeine do you feel: Irritable or wired Aches and pains

Do you adversely react to: (*check all that apply*)

- Monosodium glutamate (MSG) Aspartame (NutraSweet) Caffeine Bananas
- Garlic Onion Cheese Citrus Chocolate Alcohol Red wine
- Sulfite-containing foods (wine, dried fruit, salad bars) Preservatives (*Example: Sodium Benzoate*)
- Other: _____

Which of these significantly affect you? (*Check all that apply*)

- Cigarette smoke Perfumes/Colognes Auto exhaust fumes Other _____

In your work or home environment, are you exposed to: Chemicals Electromagnetic radiation Mold

Have you ever turned yellow (jaundiced)? Yes No

Have you ever been told you have Gilbert's syndrome or a liver disorder? Yes No

If yes, explain: _____

Do you have a known history of significant exposure to any harmful chemicals such as the following?

- Herbicides Insecticides (frequent visits of exterminator) Pesticides Organic solvents
- Heavy metals Other: _____

Chemical name, date, length of exposure: _____

Do you dry clean you clothes frequently? Yes No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures? Yes No

Do you have any pets or farm animals? Yes No If yes, explain: _____

GI HISTORY

Foreign travel? Yes No If yes, where? _____

Wilderness camping? Yes No If yes, where? _____

Have you ever had severe: Stomach pain: Yes No Diarrhea: Yes No

Do you feel like you digest your food well? Yes No

Do you feel bloated after meals? Yes No

PATIENT BIRTH HISTORY

Term Premature

Pregnancy complications: _____

Birth complications: _____

Breast fed: Yes No If yes, how long? _____

Bottle fed: Yes No

Age at introduction of: Solid foods: _____ Dairy: _____ Wheat: _____

Did you eat a lot of candy or sugar as a child? Yes No

DENTAL HISTORY

Check all that apply:

Silver mercury fillings: How many? _____

Gold fillings Root canals Implants Tooth pain Bleeding gums

Gingivitis Problems with chewing

Do you floss regularly? Yes No

FAMILY HISTORY

Please complete the following information as it relates to your family’s health history.

	If Living		If Deceased			If Living		If Deceased	
	Age	Health	Death Age	Cause		Age	Health	Death Age	Cause
Father					Spouse				
Mother					Child				
Sibling					Child				
Sibling					Child				
Sibling					Child				

Place an “X” in the appropriate column for any illnesses that your blood relatives have experienced. Take your time filling out this questionnaire and feel free to discuss these items with your family members.

ILLNESSES						ILLNESSES					
	Father	Mother	Siblings	Grand-parents	Children		Father	Mother	Siblings	Grand-parents	Children
Alcoholism						Undiagnosed Chronic Illness					
Allergies						Jaundice					
Anemia						Kidney or bladder problems					
Appendicitis						Meningitis					
Arthritis/Rheumatism						Menstrual Problems					
Asthma						Mental Illness					
Bleeding						Miscarriage / Spontaneous Abortion					
Blood pressure - high						Neuritis / Neuralgia					
Blood pressure – low						Obesity					
Bronchitis – Chronic						Pleurisy					
Bursitis, Sciatica, Lumbago						Pneumonia					
Cancer						Polio					
Cholesterol - high						Prostate problems					
Cirrhosis						Rheumatic Fever					
Colon problem						Skin Problems					
Physical Abnormalities/ Birth Defects						Stroke					
Convulsions						Stomach or Small Intestinal Disease					
Depression						Suicide- Attempt or Successful					
Diabetes						Surgeries					
Emphysema						Teeth/Gum problems					
Gall bladder disease						Transfusions					
Headache						Triglycerides-high					
Heart problems						Tuberculosis					
Hepatitis						Ulcers					
Hernia						Vaginal problems					
Hemorrhoids						Varicose Veins					
Hypoglycemia						Venereal Disease					

MSQ – MEDICAL SYMPTOM / TOXICITY QUESTIONNAIRE

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying cause of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If these symptoms are new, record your response for the last 48 hours ONLY.

POINT SCALE

0 = Never or almost never have the symptom

1 = Occasionally have it, effect is not severe

2 = Occasionally have it, effect is severe

3 = Frequently have it, effect is not severe

4 = Frequently have it, effect is severe

DIGESTIVE TRACT

- Nausea or vomiting
 Diarrhea
 Constipation
 Bloating feeling
 Belching, or passing gas
 Heartburn
 Intestinal / Stomach pain
Total:

EARS

- Itchy ears
 Earaches, ear infections
 Drainage from ear
 Ringing in ears, hearing loss
Total:

EMOTIONS

- Mood swings
 Anxiety, fear or nervousness
 Anger, irritability, or aggressiveness
 Depression
Total:

ENERGY / ACTIVITY

- Fatigue, sluggishness
 Apathy, lethargy
 Hyperactivity
 Restlessness
Total:

EYES

- Watery or itchy eyes
 Swollen, reddened or sticky eyelids
 Bags or dark circles under eyes
 Blurred or tunnel vision (does not include near- or far-sightedness)
Total:

HEAD

- Headaches
 Faintness
 Dizziness
 Insomnia
Total:

HEART

- Irregular or skipped heartbeat
 Rapid or pounding heartbeat
 Chest pain
Total:

JOINTS / MUSCLES

- Pain or aches in muscles
 Arthritis
 Stiffness
 Pain or aches in muscles
 Feeling of weakness
Total:

LUNGS

- Chest congestion
 Asthma, bronchitis
 Shortness of breath
 Difficult breathing
Total:

MIND

- Poor memory
 Confusion, poor comprehension
 Poor concentration
 Poor physical coordination
 Difficulty in making decisions
 Stuttering or stammering
 Slurred speech
 Learning disabilities
Total:

MOUTH / THROAT

- Chronic coughing
 Gagging, frequent need to clear throat
 Sore throat, hoarseness, loss of voice
 Swollen/discolored tongue, gum, lips
 Canker sores
Total:

NOSE

- Stuffy nose
 Sinus problems
 Hay fever
 Sneezing attacks
 Excessive mucus formation
Total:

SKIN

- Acne
 Hives, rashes, or dry skin
 Hair loss
 Flushing or hot flashes
 Excessive sweating
Total:

WEIGHT

- Binge eating / drinking
 Craving certain foods
 Excessive weight
 Compulsive eating
 Water retention
 Underweight
Total:

OTHER

- Frequent illness
 Frequent or urgent urination
 Genital itch or discharge
Total:

GRAND TOTAL: **KEY TO QUESTIONNAIRE**

Add individual scores and total each group. Add each group scores and give a grand total.

- Optimal: less than 10
- Mild Toxicity: 10 – 50
- Moderate Toxicity: 50 – 100
- Severe Toxicity: Over 100

SF – 36 (QUALITY OF LIFE ASSESSMENT)

INSTRUCTIONS: This set of questions asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

In general, would you say your health is: *(Please select one)*

- Excellent
- Very good
- Good
- Fair
- Poor

Compared to one year ago, how would you rate your health in general now? *(Please select one)*

- Much better than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse now than on year ago
- Much worse now than one year ago

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? *(Please select one on each line by marking with an "X".)*

Activities	Yes, Limited a Lot	Yes, Limited a Little	Not Limited at All
Vigorous activities such as running, lifting heavy objects, participating in strenuous sports			
Moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf			
Lifting or carrying groceries			
Climbing several flights of stairs			
Climbing one flight of stairs			
Bending, kneeling, or stooping			
Walking more than a mile			
Walking several blocks			
Walking one block			
Bathing or dressing yourself			

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? *(Please select one answer on each line)*

	Yes	No
Cut down on the amount of time you spent on work or other activities		
Accomplished less than you would like		
Were limited in the kind of work or other activities		
Had difficulty performing the work or other activities (for example, it took extra effort)		

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (e.g., feeling depressed or anxious)?

	Yes	No
Cut down on the amount of time you spent on work or other activities		
Accomplished less than you would like		
Didn't do work or other activities as carefully as usual		

During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? *(Please select one)*

- Not at all Quite a bit
 Slightly Extremely
 Moderately

How much physical pain have you had during the past 4 weeks? *(Please select one)*

- Not at all Quite a bit
 Slightly Extremely
 Moderately

During the past 4 weeks, how much did pain interfere with your normal work? *(Please select one)*

- Not at all Quite a bit
 A little bit Extremely
 Moderately

These questions are about how you feel and how things have been with you during the past 4 weeks. Please give the one answer that is closest to the way you have been feeling for each item.

	All of the time	Most of the time	Good bit of the time	Some of the time	A little of the time	None of the time
Did you feel full of life?						
Have you been a very nervous person?						
Have you felt calm and peaceful?						
Did you have a lot of energy?						
Have you felt downhearted and blue?						
Did you feel worn out?						
Have you been a happy person?						
Did you feel tired?						

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.?)

- All of the time A little of the time
 Most of the time None of the time
 Some of the time

How TRUE or FALSE is each of the following statements for you?

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
I seem to get sick a little easier than other people					
I am as health as anybody I know					
I expect my health to get worse					
My health is excellent					

FOR FEMALES ONLY: WOMEN’S HEALTH QUESTIONNAIRE

Obstetric History

How many times have you been pregnant? _____

Number of vaginal deliveries? _____ Number of Cesarean deliveries? _____

Reason for Cesarean delivery? _____

Number of living children? _____ Number of adopted children? _____

Largest infant? _____ Number of miscarriages? _____

Number of ectopic pregnancies? _____ Number of elective abortions? _____

Number of premature births? _____ Stillbirths? _____

Any complications of pregnancy? _____

Gynecologic History

Date of the first day of your last menstrual period? _____ Normal?: Yes / No

Do you use birth control? Yes No Type: _____

Menstrual periods come every _____ days and last for _____ days.

Age of your first menstrual period? _____

Any recent changes in your period? Yes / No If yes, please explain: _____

Do you have any of the following? (*Please circle yes or no*)

Excessive pain with your period? Yes / No

Excessive bleeding with your period? Yes / No

Premenstrual symptoms (PMS)? Yes / No

Explain: _____

Date of last PAP smear: _____ Normal / Abnormal

Would you like to be scheduled for a Gynecological Exam including a PAP smear? Yes / No

It is recommended that you have a Gynecological Exam completed within the past 12 months prior to treatment.

Have you ever had an abnormal PAP smear? Yes / No Date: _____

Date of last Mammogram: _____ Normal / Abnormal

Would you like to be referred for a mammogram? Yes / No

Have you ever had a breast lump or breast biopsy? Yes / No

Are you currently sexually active? Yes / No

Do you have pain with sexual relations? Yes / No

Have you ever had sexually transmitted disease? Yes / No

If yes, circle all that apply:

Herpes	Venereal Warts	Chlamdia	HIV
Gonorrhea	Syphilis	Pelvic Inflammatory Disease	Other

Have you stopped having menstrual periods? Yes / No When? _____

Hysterectomy? Yes / No Surgical removal of ovaries? Yes / No

Do you take Hormone Replacement Therapy? Yes / No

If yes, which medication are you taking and how do you take them? _____

Have you ever had vaginal bleeding since menopause? Yes / No

Accidental loss of urine? Yes / No Vaginal dryness? Yes / No

Hot flashes? Yes / No Pain with intercourse? Yes / No Pelvic pressure? Yes / No