Perimenopause & Menopause Health History Intake Form

Your experience is completely your own. This form helps us understand your health history, symptoms, and goals so we can support you in feeling your best during this transition.

PATIENT INFORMATION

Full Name: _____

Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Ethnic / Cultural Background: _____ Marital Status: _____

Sexual Orientation / Preference: _____ Employment / Occupation: _____

Primary Care Provider: _____ Gynecologist: _____

Who referred you? _____

YOUR PRIORITIES

What are your main health concerns?

_____

_____

What are your wellness goals?

_____

_____

What concerns do you have regarding menopause?

_____

_____

What are your thoughts about hormone replacement therapy?

BODY METRICS

Height: Current Weight: Goal Weight:

At what age / time did you feel your best?

MEDICAL HISTORY

List all current or past medical conditions:

Surgical History (surgeries, hospitalizations, major injuries):

GYNECOLOGIC HISTORY

Current Status: ☐ Premenopause ☐ Perimenopause ☐ Postmenopause

Age at first period: Last menstrual period:

Still have ovaries? ☐ Yes ☐ No Heavy periods? ☐ Yes ☐ No

Painful periods? ☐ Yes ☐ No PMS / PMDD? ☐ Yes ☐ No

History of IUD, ablation, or hysterectomy?

Recent cycle changes?

Current hormonal contraception?

Screening	Date	Screening	Date
Last Mammogram		Last Pap Smear	
Last Routine Labs		Colonoscopy	
Bone Density (DEXA)			

Pregnancies / Deliveries: Number of Children:

Currently sexually active? ☐ Yes ☐ No Partner gender: ☐ Yes ☐ No

Length of current relationship:

ALLERGIES

List allergies and reactions:

MEDICATIONS & SUPPLEMENTS

Medication / Supplement	Dose	Frequency	When Started

FAMILY HISTORY

Significant medical conditions, cancers (type), osteoporosis, heart disease:

LIFESTYLE

Exercise (type, frequency, duration):

Diet (meals/day, dietary style):

Smoker: ☐ Yes ☐ No Caffeine (cups/day): _____ Alcohol (drinks/week): _____

Stress level (1–10): Stress management practices:

History of physical, emotional, or sexual abuse (optional):

SYMPTOM CHECKLIST

Please indicate severity for each symptom.

Symptom	Mild	Moderate	Severe
Hot flashes	☐	☐	☐
Night sweats	☐	☐	☐
Sleep disturbances	☐	☐	☐
Brain fog	☐	☐	☐
Memory concerns	☐	☐	☐
Word recall difficulty	☐	☐	☐
Difficulty concentrating	☐	☐	☐
Irritability	☐	☐	☐
Joint pain	☐	☐	☐
Extreme fatigue	☐	☐	☐
Weight gain	☐	☐	☐
Anxiety	☐	☐	☐
Mood swings	☐	☐	☐
Depressed mood	☐	☐	☐

Symptom	Mild	Moderate	Severe
Headaches	☐	☐	☐
Heart palpitations	☐	☐	☐
Low libido	☐	☐	☐
Vaginal dryness	☐	☐	☐
Pain with intercourse	☐	☐	☐
Bleeding with intercourse	☐	☐	☐
Recurrent vaginal infections	☐	☐	☐
Urinary frequency	☐	☐	☐
Urinary urgency	☐	☐	☐
Urine leakage	☐	☐	☐
Recurrent UTIs	☐	☐	☐
Itchy skin	☐	☐	☐
Itchy ears	☐	☐	☐
Breast tenderness	☐	☐	☐

READINESS FOR CHANGE

On a scale of 1–10, how willing are you to make lifestyle or nutrition changes?

1	2	3	4	5	6	7	8	9	10

Not willing *Very willing*

ADDITIONAL INFORMATION

Anything else you would like your provider to know:

Thank you for taking the time to complete this form. Your answers help us provide the most personalized, effective care possible.