

DuPage Neurology & Wellness Center

Menopausal Female Health Assessment Form

Name: _____ Age: _____ Sex: _____ Date: _____

Please list your 5 major health concerns in your order of importance:

- | | | |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | |

Please rate the following. Note: If symptom is being treated pharmaceutically, * the question and indicate symptoms both with and without treatment.

		Never	Always		Never	Always			
Section M-1 C				Section M-6 HG					
Feeling that bowels do not empty completely	0	1	2	3	Find it difficult to eat large meals in morning	0	1	2	3
Lower abdominal pain relief by passing stool/gas	0	1	2	3	Crave sweets during the afternoon	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3	Energy levels drop in the afternoon	0	1	2	3
Diarrhea	0	1	2	3	Irritable if meals are missed	0	1	2	3
Constipation	0	1	2	3	Depend on coffee to keep yourself going	0	1	2	3
Hard, dry, or small stool	0	1	2	3	Get lightheaded if meals are missed	0	1	2	3
Coated tongue/fuzzy debris on tongue	0	1	2	3	Difficulty concentrating before eating	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3	Eating relieves fatigue/energizes	0	1	2	3
More than 3 bowel movements daily	0	1	2	3	Feel shaky, jittery, tremors	0	1	2	3
Use laxatives frequently	0	1	2	3	Agitated, easily upset, nervous between meals	0	1	2	3
Black/tarry stools or blood in stool	0	1	2	3	Poor memory, forgetful	0	1	2	3
					Blurred vision	0	1	2	3
					Wake up in the middle of the night	0	1	2	3
Section M-2 Hypo-A					Section M-7 IR				
Excessive belching, burping, or bloating	0	1	2	3	Fatigue after meals	0	1	2	3
Gas immediately following a meal	0	1	2	3	Feel you need stimulants such as coffee after meals	0	1	2	3
Offensive breath	0	1	2	3	Crave sweets during the day	0	1	2	3
Difficult bowel movements	0	1	2	3	Eating sweets does not relieve cravings for sugar	0	1	2	3
Sense of fullness during and after meals	0	1	2	3	Crave sweets after meals	0	1	2	3
Difficulty digesting fruits and vegetables; or undigested foods found in stools	0	1	2	3	Waist girth is equal to or larger than hip girth	0	1	2	3
Section M-3 Hyper-A					Frequent urination	0	1	2	3
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3	Increased thirst and appetite	0	1	2	3
Do you frequently use antacids?	0	1	2	3	Difficulty losing weight	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3	Weight gain when under stress	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3	Difficulty fall asleep	0	1	2	3
Temporary relief from antacids, food, milk, or carbonated beverages	0	1	2	3					
Digestive problems subside with rest and relaxation	0	1	2	3	Section M-8 Hypo-C				
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3	Cannot stay asleep	0	1	2	3
Section M-4 SI					Crave salt	0	1	2	3
Roughage and fiber cause constipation	0	1	2	3	Slow starter in the morning	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3	Afternoon fatigue	0	1	2	3
Pain, tenderness, soreness-left side under rib cage	0	1	2	3	Dizziness when standing up quickly	0	1	2	3
Excessive passage of gas	0	1	2	3	Afternoon headaches	0	1	2	3
Nausea and/or vomiting	0	1	2	3	Headaches with exertion or stress	0	1	2	3
Stool undigested, foul-smelling, mucous-like, greasy, or poorly formed	0	1	2	3	Weak nails	0	1	2	3
Frequent urination	0	1	2	3	Hemorrhoids	0	1	2	3
Increased thirst and appetite	0	1	2	3					
Difficulty losing weight	0	1	2	3	Section M-9 Hyper-C				
Section M-5 GB					Cannot fall asleep	0	1	2	3
Greasy or high fat foods cause distress	0	1	2	3	Excessive perspiration or perspiration with little or no activity	0	1	2	3
Lower bowel gas and or bloating several hours after eating	0	1	2	3	Under high amounts of stress	0	1	2	3
Bitter, metallic taste in mouth, especially in the morning	0	1	2	3	Weight gain when under stress	0	1	2	3
Unexplained itchy skin	0	1	2	3	Wake up tired even after 6 or more hours of sleep	0	1	2	3
Yellowish cast to eyes	0	1	2	3					
Stool color alternates-clay colored/normal brown	0	1	2	3	Section M-10 Hypo-T				
Reddened skin, especially palms	0	1	2	3	Tired, sluggish	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3	Feel cold-hands, feet, all over	0	1	2	3
Problems with burping up fish oil supplements	0	1	2	3	Require excessive amounts of sleep to function properly	0	1	2	3
History of mid-back pain	0	1	2	3	Increase in weight gain, even with low calorie diet	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3	Gain weight easily	0	1	2	3
Has gallbladder been removed?	Yes	No			Difficult, infrequent bowel movements	0	1	2	3
					Depression, lack of motivation	0	1	2	3
					Morning headaches that wear off as the day progresses	0	1	2	3
					Outer third of eyebrow thins	0	1	2	3
					Thinning of hair on scalp, face, or genitals, or excessive falling hair	0	1	2	3
					Dryness of skin and/or scalp	0	1	2	3
					Mental sluggishness	0	1	2	3
					Difficulty driving/seeing objects at night	0	1	2	3
					Do you have amalgam fillings (metal)	Yes	No		

Section M-11 Hyper-T

	Never	Always		
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse, even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Section M-12 Hypo-P

	Never	Always		
Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Section M-13 Hyper-P

	Never	Always		
Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" type headaches	0	1	2	3

Section M-16 Hormones

	Never	Always		
How many years have you been menopausal? <input type="checkbox"/> Surgical				
Since menopause, do you ever have uterine bleeding?	0	1	2	3
Hot flashes	0	1	2	3
Mental foginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3
Length of cycle _____ days Date of last GYN exam _____				
Mammogram <input type="checkbox"/> + <input type="checkbox"/> - PAP <input type="checkbox"/> + <input type="checkbox"/> -				
# of children _____ # of pregnancies _____ <input type="checkbox"/> C-section				
<input type="checkbox"/> P.I.D <input type="checkbox"/> Vaginal inf. <input type="checkbox"/> Endometriosis <input type="checkbox"/> Infertility <input type="checkbox"/> Fibrocystic breasts				
<input type="checkbox"/> Fibroids/ovarian cysts				

Section M-17 AI

Does Echinacea make your symptoms better/worse?	B	W	?	
Does coffee make your symptoms better/worse?	B	W	?	
<i>-Women who have given birth</i>				
Found it difficult to lose weight since pregnancy	0	1	2	3
Health has seemed to decline since pregnancy	0	1	2	3
Gums bleed when you brush your teeth	0	1	2	3
Bruise easily	0	1	2	3

Section NT-1 General Function

	Never	Always		
Is your memory noticeably declining?	0	1	2	3
Are you having a hard time remembering names and phone numbers?	0	1	2	3
Is your ability to focus noticeably declining?	0	1	2	3
Has it become harder for you to learn things?	0	1	2	3
Have a hard time remembering your appointments?	0	1	2	3
Is your temperament getting worse in general?	0	1	2	3
Are you losing your attention span endurance?	0	1	2	3
Find yourself down or sad?	0	1	2	3
Fatigue when driving compared to the past?	0	1	2	3
Fatigue when reading compared to the past?	0	1	2	3
How often do you walk into rooms and forget why?	0	1	2	3
How often do you pick up your cell phone and forget why?	0	1	2	3
Ever used GABA to fall asleep?	Yes	No		

Section NT-2 Stress

	Never	Always		
You are under a high amount of stress	0	1	2	3
Feel that you have something that must be done	0	1	2	3
Feel you never have time for yourself	0	1	2	3
Feel you are not getting enough sleep or rest	0	1	2	3
You are getting regular exercise	0	1	2	3
Feel as if people don't care about you	0	1	2	3
Feel you are not accomplishing your life's purpose	0	1	2	3
Feel you have no one to share your problems with	0	1	2	3
Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being lowest)				
No stress 1 2 3 4 5 6 7 8 9 10 Extreme stress				

Section NT-3 S

	Never	Always		
Losing your pleasure in hobbies and interests	0	1	2	3
Feel overwhelmed with ideas to manage	0	1	2	3
Have feelings of inner rage (anger)	0	1	2	3
Feelings of paranoia	0	1	2	3
Feel sad or down for no reason	0	1	2	3
Feel like you are not enjoying life	0	1	2	3
Feel you lack artistic appreciation	0	1	2	3
Feel depressed in overcast weather	0	1	2	3
Losing enjoyment for your favorite activities	0	1	2	3
Losing enjoyment for your favorite foods	0	1	2	3
Losing enjoyment of friendships/relationships	0	1	2	3
Difficulty falling into a deep restful sleep	0	1	2	3
Have feelings of dependency on others	0	1	2	3
Feel an increased susceptibility to pain	0	1	2	3
Have feelings of unprovoked anger	0	1	2	3
Losing interest in life	0	1	2	3

Section NT-4 D

	Never	Always		
Have feelings of hopelessness	0	1	2	3
Have self-destructive thoughts	0	1	2	3
Have an inability to handle stress	0	1	2	3
Have anger/aggression while under stress	0	1	2	3
Feel unrested even after long hours of sleep	0	1	2	3
Prefer to isolate yourself from others	0	1	2	3
Unexplained lack of concern for family/friends	0	1	2	3
Easily distracted from tasks	0	1	2	3
Inability to finish tasks	0	1	2	3
Feel need to consume caffeine to stay alert	0	1	2	3
Feel your libido has decreased	0	1	2	3
Lose your temper for minor reasons	0	1	2	3
Have feelings of worthlessness	0	1	2	3

Section NT-5 G

	Never	Always		
Feel anxious or panic for no reason	0	1	2	3
Feelings of dread or impending doom	0	1	2	3
Feel knots in your stomach	0	1	2	3
Feelings of being overwhelmed for no reason	0	1	2	3
Feelings of guilt about everyday decisions	0	1	2	3
Mind feels restless	0	1	2	3
Find it difficult to turn your mind off when you want to relax	0	1	2	3
Feelings of disorganized attention	0	1	2	3
Worry about things that you were not worried about before	0	1	2	3
Feelings of inner tension and inner excitability	0	1	2	3

Section NT-6 ACH

	Never	Always		
Feel your visual memory (shapes and images) has decreased	0	1	2	3
Feel your verbal memory is decreased	0	1	2	3
Memory lapses	0	1	2	3
Decrease in creativity	0	1	2	3
Decrease in comprehension	0	1	2	3
Difficulty calculating numbers	0	1	2	3
Difficulty recognizing objects/faces	0	1	2	3
Feel like your opinion of yourself has changed	0	1	2	3
Excessive urination	0	1	2	3
Slower mental response	0	1	2	3

Health Habits

- Tobacco:
Cigarettes: #/day
Cigars: #/day
Alcohol:
Wine: # glasses d / w
Liquor: # ounces d / w
Beer: # glasses d / w
Caffeine:
Coffee: # 6 oz cups/d
Tea: # 6 oz cups/d
Soda: # cans/d
Other sources
water: # glasses/d
Skin creams

Exercise

- 5-7 days per week
 3-4 days per week
 1-2 days per week
 45 min or more duration/workout
 30-45 min duration/workout
 Less than 30 min/workout
 Walk # days/week
 Run/other aerobic days/week
 Weight lift # days/week
 Stretch # days/week
 Other

Nutrition/Diet

- Mixed food (animal/veg sources)
 Vegetarian
 Vegan
 Salt restriction
 Fat restriction
 Starch/carbohydrate restriction
 Total calorie restriction
Specific food restrictions:
 Dairy Wheat/gluten
 Eggs Soy Corn
 Other

The three worst foods you eat during the average week?

The three healthiest foods you eat during the average week?

Favorite food

Food Frequency

- Number servings per day:
Fruits (citrus, melons, etc)
Dark green, yellow/orange veg
Grains (unprocessed)
Beans, peas, legumes
Dairy Eggs
Meat, poultry, fish

Eating Habits

- Skip meals
meals consumed/day
 Graze (small frequent meals)
 Generally eat on the run
 Eat constantly, hungry or not

Do you consider yourself:
 Underweight Overweight
 Just right Weight today

Bowel movements/day

Updated 03/11/11

Current Supplements

- Multivitamin/mineral
 Vitamin C
 Vitamin E
 EPA/DHA
 Calcium
 Magnesium
 Zinc
 Probiotics
 Digestive Enzymes
 CoQ10
 Herbs
 Homeopathy
 Protein Shakes/liquid meals
 Others

Medication History

Circle if currently taking and indicate duration

- Antacids
 Antibiotics
 Antifungals
 Antihistamines
 Antidepressants
 Insulin Support Agents
 NSAIDS/Anti-inflammatory agents
 Anxiety Medications
 Blood pressure lowering agents
 Cholesterol lowering agents
 Oral Contraceptives
 Hormones
 Laxatives
 Diuretics
 Cortisone (cream/injection/pill)

Other medications, including over-the-counter meds. Indicate reason for taking and length of time on each medication.

Review of Systems

Eyes/Vision

- Wear glasses/contacts
 Recent change in vision
 Cataracts
 Eye pain
 Glaucoma
 Macular Degeneration

Cardiovascular

- Chest pain/discomfort
 Leg pain/ache
 Heaviness in legs
 Pain in shoulder/jaw
 Heart murmur
 Palpitations
 Rapid pulse
 High blood pressure
 Low blood pressure
 Varicose veins
 Swelling in feet/ankles
 Difficulty breathing when lying down
 Wake at night with shortness of breath

Respiration

- Cough
 Shortness of breath
 Wheezing
 Excessive sputum production
 Emphysema

Skin

- Unusual pattern of hair growth
 Changes in skin color
 Changes in wart/mole
 Hives
 Sore that won't heal
 Itching
 Rash
 Skin lesions/ulcers

Medical History

Please indicate if you have, or have ever had, any of the following:

- Allergies
 Arthritis
 Alzheimer's disease
 Bronchitis
 Cancer
 Chronic fatigue syndrome
 Carpal tunnel syndrome
 Cholesterol/triglycerides elevated
 Colitis
 Eating disorder
 Epilepsy
 Fibromyalgia
 Food intolerances
 Gastroesophageal reflux disease
 Gout
 Heart disease
 Kidney disease/stones
 Learning disability
 Liver disease
 Mental illness
 Neurological problems
 Obesity
 Osteoarthritis
 Pneumonia
 Sexually transmitted disease
 Skin cancer
 Stroke
 Thrombophlebitis
 Tuberculosis
 Type II Diabetes
 Urinary tract infections

Section A1

- Alopecia Areata
 Asthma
 Celiac Disease
 Crohn's Disease*
 Dermatomyositis
 Endometriosis
 Grave's Disease
 Hashimoto's disease
 Interstitial Cystitis
 Lupus Erythematosus (SLE)
 Multiple Sclerosis*
 Myasthenia Gravis*
 Narcolepsy
 Pernicious Anemia
 Psoriasis*
 Rheumatoid Arthritis
 Schizophrenia*
 Scleroderma

- Sjogren's Syndrome*
 Temporal Arteritis
 Type I Diabetes
 Ulcerative Colitis
 Vasculitis
 Vitiligo
 Wegener's Granulomatosis

Section C

- Addison's Disease
 Anemia
 Ataxia/Nerve Disease/Neuropathy
 Attention Deficit Disorder
 Autism
 Bacterial Overgrowth (Intestinal)
 Bloating, gas, or stomach cramping

- Candida Albicans
 Canker Sores
 Casein/Lactose Intolerance
 Chronic Fatigue Syndrome
 Cognitive Impairment
 Constipation
 Diarrhea or runny stools
 Depression
 Dermatitis Herpetiformis
 Dyspepsia/Acid Reflux
 Eczema
 Epilepsy
 Fibromyalgia
 Flatulence (Gas)
 Gallbladder Disease
 Gastrointestinal Bleeding
 Growth Hormone Deficiency
 Heart Failure
 Joint Pain
 Infertility/Miscarriage
 Inflammatory Bowel Disease
 Intestinal Permeability
 Irritable Bowel Syndrome
 Kidney Disease
 Lactose Intolerance
 Liver Disease
 Malnutrition
 Migraines or headaches
 Non-Hodgkin's Lymphoma
 Numbness/tingling in extremities
 Obesity
 Osteopenia/-porosis
 Pancreatic Disorders
 Peripheral Neuropathy
 Psychiatric disorders
 Sarcoidosis
 Sepsis
 Small Intestinal Cancer
 Thrombocytopenic Purpura
 Thyroid disorders
 Tuberculosis

Family history of the above conditions (* item if it was cause of death)

Traveled outside the U.S. in past 5 years

I Would Like to:

Energy/Vitality

- Feel more vital
- Have more energy
- Have more endurance
- Be less tired after lunch
- Sleep better
- Be free of pain
- Get less colds and flu
- Get rid of allergies
- Not be dependent upon OTC meds like aspirin, ibuprofen, anti-histamines, sleep aids, etc.
- Stop using laxatives and stool softeners
- Improve sex drive

Body Composition

- Loose Weight
- Burn more body fat
- Be stronger
- Have better muscle tone
- Be more flexible

Stress, Mental, Emotional

- Learn how to reduce stress
- Think more clearly and be more focused
- Improve memory
- Be less depressed
- Be less moody
- Be less indecisive
- Feel more motivated

Life Enrichment

- Reduce my risk of degenerative disease
- Slow down accelerated aging
- Maintain a healthier life longer
- Change from a "treating illness" orientation to creating a wellness lifestyle

Patient signature/date