Praxisgemeinschaft
AM ENGLISCHEN GARTEN

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Anamnesis form for women during menopause

Dear patient,

for your individual consultation regarding your troubles with menopause, we need specific details about your current ailments. This helps us to adjust our treatment to your specific needs.

How can we reach you? landline: ..... mobile:.....

e-mail-adress: .....

your current profession: .....

your height: ..... cm your weight: ..... kg

Gynaecological anamnesis:

Do you suffer or have previously suffered from following diseases?

endometriosis ○ no ○ yes

myoma of the uterus ○ no ○ yes

other diseases of your lower abdomen, e.g. cysts, infections ○ no ○ yes, which.....

diseases of the breast ○ no ○ yes, which.....

Have you ever had a gynaecological operation done?

○ no ○ yes, which .....

Have you had any miscarriages/abortions/ectopic pregnancies up until now?

date	miscarriage	abortion	ectopic pregnancy

Have you given birth to any children?

date	Type of birth	Weight at birth	complications

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Menstrual period:

When was your last and second last period? .....

If you still have your period:

Do your periods appear at irregular intervals? ○ no ○ yes

Has your period changed in the past two years? ○ no ○ yes

If yes, how: ○ more often ○ less often ○ more intense ○ less intense

What preventive medical check-ups have you had lately?

When was your last mammographie/breast ultrasound? .....

When was your last gynaecological check-up? .....

Have you had any other medical examinations? (e.g. colonoscopy)

If yes, which and when? .....

When was your last vaginal ultrasound? .....

Have you ever had a measurement of your bone density? .....

Was there anything out of the ordinary with your results? .....

Menopausal symptoms (none – slighty – medium – severe):

	Do you have any of the following symptoms?	none	slightly	medium	severe
1	Hot flush, sweating (rising heat, night sweats)				
2	Sleeping disorders (difficulty falling asleep or staying alseep, waking up early)				
3	Depressive mood (sadness, lack of drive, mood swings)				
4	Irritability (nervousness, inner tension, aggressiveness)				
5	Anxiety (inner peace, panic)				
6	Heart problems (racing or beating heart, cardiac stumbling)				
7	Physical tiredness, general performance degradation				
8	Problems with concentration, forgetfullness				
9	Sexual changes (changes in libido or sexual arousal or the orgasm) Does this bother you? yes ○ no ○				
10	Vaginal dryness (dryness or a burning sensation, problems with sexual intercourse)				
11	Urinary tract problems (struggling to urinate, frequent urination, repeated infection of the urinary tract, involuntary urination)				
12	Joint or muscle complaints (similar to rheumatism)				
13	Hair loss				
14	Dizziness				
15	Tension in the breast, chest pain				

16	Further not mentioned symptoms ..... Which of these symptoms trouble you the most? .....

Circumstances, risk factors and symptoms:

Do you or did you use to smoke? ○ no ○ yes, how much.....

Do you regularly consume alcohol? ○ no ○ yes, how much.....

Has your weight changed? ○ no ○ yes, how many kg (+/-) .....

Are you active regularly? ○ often ○ sometimes ○ rarely

Do you have a tendency to faint or get headaches? ○ no ○ yes

Do you have or have you had any broken bones? ○ no ○ yes

Medication:

Do you take any medication or plant-based preparations/supplements regularly?

○ no ○ yes, the following .....

Have you ever had a high dosage cortison treatment for a longer amount of time in the past?

○ no ○ yes

Have you had or do you currently have any of the following diseases?

disease	no	yes
High blood pressure		
Thrombosis or pulmonary embolism		
Heart attack or stroke		
Varicose veins		
Others (angina pectoris, heart failure, cardiac arrythmia)		
Cancer If yes, what type		
Disorders of the nervous system e.g. migranes, epilepsy		
Metabolic disorders e.g. high blood lipid levels		
Diabetes mellitus		
Blood clotting disorder		
Thyroid disorder		
Disorder of the adrenal cortex		
Pulmonary diseases e.g. asthma, COPD		
Disorders of the liver, bile, pancreas		
Diseases of th bone or connective tissue e.g. osteoporosis, arthrosis		
Mental disorder If yes, which		
Allergies or any intolerances If yes, which		

Other diseases If yes, which		

Anamnesis of your family history

Does a close relative of yours (mother, father, siblings) have any of the diseases mentioned above or any other grave illnesses

If yes, which .....

.....

Individual questions

Have you ever took some steps to better your menopausal symptoms? ○ no ○ yes

If yes, what? .....

.....

.....

Vaccination

Is your vaccination completed? ○ no ○ yes

Do you have a vaccination certification? ○ no ○ yes

Are you vaccinated aginst shingles and pneumococcus? ○ no ○ yes

Do you have any specific wishes or expectations for your menopausal therapy?

○ no ○ yes, which

.....

.....

.....

Do you have any further questions regarding a specific topic?? ○ no ○ yes

If yes, which? .....

.....

place, date: ..... signature : .....