Dr. Honey & Dr. Cochen
Obstetrics and Gynecology

Consult for Postmenopausal Bleeding

Name:______________________________ **Date:___________**

Please answer the following:

What is your age?_____________
How many times have you been pregnant?_______ Number of children?___________________________
What year did your menopause begin(no bleeding for a year)? __________________________________
When did you experience postmenopausal bleeding?____
How heavy was it?___________How many days did it last?_____________________________________
Are you on hormones?__________Which ones/doses:____

General health:
Do you have high blood pressure? (Y / N) Do you have diabetes? (Y / N)
List any other medical conditions that you have:____
Have you been diagnosed with Sleep Apnea? (Y / N)
List any surgeries that you have had:____
List your medications and dosages:____
List your allergies to medications**:**_____________________________Latex Allergy? (Y / N)
Are you a smoker? (Y / N). How Much?______. Drinks per week______. Cannibis? (Y / N)
When was your last Pap smear?____________. Have you had any abnormal Paps? (Y / N)

Family History:

Do you have a family history of breast, ovary, uterine or cervical cancer? (Y / N)
Please list which family member had which of the above cancers:__________________________________

Social History:

Do you have a partner?___________
What do you do for a living?__________________________________

What is your greatest concern today?____

Thank you for completing this questionnaire!

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