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## REPRODUCTIVE HISTORY

### MENSTRUAL CYCLE:

**Please choose one of the following alternatives which best describes your menstrual cycle pattern:**

- a. Over the past 12 months, my menstrual cycles have been regular and there has been NO CHANGE in cycle length.
- b. I have menstruated in the last 3 months, but I have experienced a change in menstrual frequency (more or less frequent periods).
- c. I have not had a menstrual period in the last 3 months, but had at least 1 menstrual period in the last 12 months.
- d. I have not had a menstrual period in the last 12 months.

Are your periods (or were your periods) usually regular?

- No
- Yes

If you have had a menstrual period in the last 12 months, please indicate the APPROXIMATE date of the 1st day of bleeding of your last menstrual period.

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### BIRTH CONTROL

If applicable, please indicate the method of birth control that you are currently using:

- None
- Sterilization (tubes tied)
- Male partner vasectomy
- Birth-control pill, ring, or skin patch
- IUD: MIRENA
- IUD: Other
- Injectable hormone
- Implanted hormone
- Diaphragm
- Foam / gel
- Condoms
- Natural family planning / Rhythm
- Other

Please indicate how you have been feeling in the PAST WEEK, including today, by selecting the alternative that best corresponds to your experience for each of the following:

	<b>Not at all</b>	<b>A little, or some of the time</b>	<b>Often</b>	<b>Most, or all of the time</b>
1. I have been feeling bad				
2. I have been feeling ready to explode				
3. I have yelled at other				
4. I have been irritable when someone touched me.				
5. I have been easily flying off the handle				
6. It feels like there has been a cloud of anger over me				
7. I have been rather sensitive				
8. I have been quick to criticize others				
9. Noises seemed louder				
10. I have been getting annoyed with myself				
11. I have been so angry that I lost control				
12. There has been a flood of tension through my body				
13. I said nasty things to others that I did not mean				
14. It took very little for things to bother me.				

Please answer the following 11 questions if you have experienced a change in your menstrual cycle (if you indicated option b, c, or d on the Menstrual Cycle question) .

	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>	<b>Very Severe</b>
1. Hot flushes, sweating					
2. Heart discomfort (heart skipping, racing, tightness)					
3. Sleep problems					
4. Depressive mood					
5. Irritability					
6. Anxiety					
7. Physical and mental exhaustion (poor concentration, forgetful)					
8. Sexual problems					
9. Bladder problems					
10. Dryness of vagina					
11. Joint and muscular discomfort					

HOT FLASHES:

Are you experiencing hot flashes or night sweats?

\_\_\_ No (Skip this section)

\_\_\_ Yes

if yes:

\* How long have you had hot flashes?

\_\_\_ Less than 2 years

\_\_\_ More than 2 years

\* Most of your hot flashes are:

\_\_\_ During the night

\_\_\_ During the day

\* In a 24-hour period, how many hot flashes do you usually have?

\_\_\_ Fewer than 5 episodes

\_\_\_ 5 to 10 hot flashes

\_\_\_ More than 10 hot flashes

\* How long do your hot flashes usually last?

\_\_\_ 5 minutes or less

\_\_\_ Longer than 5 minutes

\* How intense are your hot flashes?

\_\_\_ I usually feel mildly sweaty

\_\_\_ I usually feel drenched with sweat

\* Do your hot flashes interrupt your daily activities?

Yes, some of the time

Yes, some of the time

No, never

\* Do your hot flashes interrupt your sleep at night?

Yes, some of the time

Yes, some of the time

No, never

Are you taking hormone replacement therapy?

No

Yes

If yes, please specify the medication and dosage: \_\_\_\_\_

\_\_\_\_\_

Do you have, or have you ever sought treatment for the following medical conditions or illnesses (please specify where appropriate)

Diabetes

Thyroid disorder

Heart condition

High / low blood pressure

High cholesterol

Cancer

Other, please specify \_\_\_\_\_

If you answered yes to any of the above, please provide date of diagnosis and treatment

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