The Johns Hopkins   
Reproductive Mental Health Center

Perimenopause Evaluation Questionnaire

Please answer as completely as possible. When you are finished, please upload this form to the following [this secure site](https://nam02.safelinks.protection.outlook.com/?url=https%3A%2F%2Flivejohnshopkins-my.sharepoint.com%2F%3Af%3A%2Fg%2Fpersonal%2Facraig14_jh_edu%2FEoCOnHhYgD1LhW9Zb-2oYEwBySvVEgMV27y4CHuIF3tTPw&data=04%7C01%7Chkim10%40jhmi.edu%7Ce35a2187fc0d42406b3808d955b90b0f%7C9fa4f438b1e6473b803f86f8aedf0dec%7C0%7C0%7C637635075514206957%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=AkKCGI6MEH4EArWMkvQTKQ35aLtQyY%2BZdacNCVVwlr8%3D&reserved=0) (preferred) or email it to our administrative coordinator, Allison Craig at [acraig14@jhmi.edu](mailto:acraig14@jhmi.edu).

Once you have returned this form we will contact you to provide you with some possible dates for your evaluation. Please check your email and respond in less than one week or your appointment slot may be given to the next patient on our waitlist.

1. Who referred you to our program?
   1. Self-Referred
   2. Provider -- NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Please tell us in one to two sentences why you are seeking this evaluation.
3. Are you seeking a one-time evaluation or ongoing medication management care?
   1. One-time evaluation
   2. Ongoing medication management
   3. All the above if available

(Please note that if you are looking to establish ongoing care at our clinic, this will be discussed during your initial evaluation. Please note that we cannot guarantee ongoing care as spots are limited. You should not assume that any new medications will be prescribed at your evaluation appointment or that you will be able to establish care at our clinic during your evaluation appointment.)

1. If you are interested in ongoing medication management care, are you routinely available on Thursday afternoons?
   1. YES
   2. NO
   3. OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What is your preferred language?
3. Do you require an interpreter? **YES** **NO**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION FORM** | | | | | | |
| **DEMOGRAPHICS** | | | | | | |
| **Existing Hopkins Patient MRN:** | | | | **New Patient YES/NO** | | |
| Name: | | | | | | |
| Date of birth: | | SSN: | | | | Race: |
| Religion: | | Country of Birth: | | | | Marital Status: |
| Address: | | | | | | |
| City: | | State: | | | | ZIP Code: |
| Phone: | | Cell: | | | | |
| Male \_\_\_\_ Female\_\_\_\_\_\_ Non-Binary \_\_\_\_\_\_ Mother’s Maiden Name: | | | | | | |
| Email: (If we may contact you by email) | | | | | | |
| **EMERGENCY:** | | | | | | |
| Name: | | | | | Relationship: | |
| Address: | | | | | | |
| Phone: | | | | | Email: | |
| **MEDICAL INFORMATION:** | | | | | | |
|  | | | | | | |
| Clinical Diagnosis: | | | | | | |
| Treating Psychiatrist (Name, address): | | | | | | |
| Treating Therapist/Counselor (Name, address): | | | | | | |
| Primary Care Physician (Name, address): | | | | | | |
| Psychiatrically Hospitalized: Y/N - Yes | If yes, When: | | | | | |
| Current Medications (names and dosage): | | | | | | |
|  | | | | | | |
| Allergies: | | | | | | |
| \*Is this appointment accident related? Y/N | | | | | | |
| \*Preferred Language: | | | | | Need Translator: Y/N | |
| **INSURANCE** | | | | | | |
|  | | | | | | |
| **Primary Insurance:** | | | **Subscriber:** | | | |
| In Network? Y N | | Fee Due at Time of Service: | | | | |
| **Member ID:** | | | | | | |
|  | | | | | | |
| **Secondary Insurance:** | | | **Subscriber:** | | | |
| In Network: Y N | |  | | | | |
| **Member ID:** | | | | | | |
| Additional Information: | | | | | | |
|  | | | | | | |

**These questions relate to the menopausal transition. *Perimenopause* is the period leading up to menopause. Most women recognize it as the time during which they begin to have irregular periods; it typically lasts 2-6 years but can be longer. *Menopause* is the one-year anniversary of your last menstrual cycle. Our perimenopausal evaluations are meant for women with symptoms that occur during this transition. If you are several years past menopause, your symptoms are likely not related to the transition and you should return to our website for help seeking a general psychiatric consultation.**

1. What was the approximate date of your last menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What approximate date did your menstrual cycles first become irregular? (perimenopause) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you post-menopausal? (Answer YES, if your last menstrual period was over one year ago?) **YES** **NO**
2. What happened that made you think you were in perimenopause? (Please check all that apply – continued to next page)

( ) Hot flashes ( ) Night sweats

( ) Weight gain ( ) Vaginal dryness

( ) Irregular periods ( ) Phantom periods

( ) Shorter, lighter periods ( ) Heavier periods or flooding

( ) Shorter cycles ( ) Longer cycles

( ) Loss of interest in sex ( ) Changes in hair growth

( ) Difficulty Sleeping ( ) Mood swings

( ) Low mood or depression ( ) Easy tearfulness

( ) Decreased ability to concentration ( ) Memory problems

( ) Irritability ( ) Incontinence

( ) My doctor informed me that I was menopausal

( ) I felt I was just at that age

( ) Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you received any medical treatment, such as a hysterectomy or chemotherapy, that precipitated menopause? **YES** **NO**

If yes, what treatment did you receive? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Did you or do you currently take hormone replacement therapy (HRT)?

( ) YES, I am currently on HRT

( ) YES, I have taken HRT but do not currently

( ) NO, I do not and have never taken HRT

If yes, has it alleviated any mood symptoms? **YES NO**

**Please fill out the following chart. It lists some mood symptoms. Please indicate the extent to which you felt these mood symptoms during perimenopause and, if applicable, after menopause.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **During perimenopause** | | | | **After menopause (no menstrual cycles for one year)** | | | |
| Symptom | Not at all | Mild | Moderate | Severe | Not at all | Mild | Moderate | Severe |
| 1. Depressed mood or feelings of hopelessness |  |  |  |  |  |  |  |  |
| 2. Increased mood swings. |  |  |  |  |  |  |  |  |
| 3. Feelings of elation or agitation associated with symptoms like an exaggerated self-confidence; decreased need for sleep without a loss of energy; a sense that thoughts are racing; or increased activities or plans. |  |  |  |  |  |  |  |  |
| 4. Improved mood (specifically an *improvement* in the symptoms of your mood disorder) |  |  |  |  |  |  |  |  |
| 5. Feeling very anxious, more so than what you would consider normal |  |  |  |  |  |  |  |  |
| 6. Recurrent, unwanted, intrusive ideas, images, or impulses that seem silly or horrible |  |  |  |  |  |  |  |  |
| 7. Feeling the need to check things over and over, or repeat actions over and over, in order to prevent bad things from happening |  |  |  |  |  |  |  |  |
| 8. Having panic attacks. (Panic attacks are sudden unexpected episodes of anxiety often associated with physical symptoms such as rapid heartbeat, feeling faint, lightheaded, trembling, chest tightness, or shortness of breath; lasting approximately 10 minutes) |  |  |  |  |  |  |  |  |

**Have your symptoms, listed above, interfered with:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at all | Mild | Moderate | Severe |
| A. Your work efficiency |  |  |  |  |
| B. Your relationships with coworkers |  |  |  |  |
| C. Your relationships with your family |  |  |  |  |
| D. Your social life activities |  |  |  |  |
| E. Your home responsibilities |  |  |  |  |

Thank you! The information above is all that we will need to schedule your appointment. Below is a checklist to help you prepare for your appointment – please ensure that items on this list are received **at least two weeks before your appointment**.

**Please obtain:**

REQUIRED:

□ Typed summary of care letter from your psychiatric provider. The summary of care should include your primary psychiatric diagnoses and medication trials to date (preferably with dates, efficacy, side effects and reasons medication discontinued). Your provider may also use this table [(link to medication table form – Word file here](https://www.hopkinsmedicine.org/psychiatry/specialty_areas/moods/patient_information/docs/women/WRMH_Medication_Table_Jul2021.docx)) to summarize medication trials to date. The link to this form can also be found on our website.

□ Signed Release of information ([link to pdf form](https://www.hopkinsmedicine.org/the_johns_hopkins_hospital/_docs/a_2_1_a_providers_authorization.pdf)) to receive your information and send our recommendations to your current psychiatric providers. The link to this form also be found on our website.

PREFERRED (if available, but not required at first appt):

□ Summary of care from any treating therapist/counselor.

\*\*\*\* Failure to return the required items on the above checklist at least two weeks prior to your evaluation appointment may result in our needing to cancel or reschedule. Please sign below indicating that you have read this information and are in agreement with these terms.

SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cancellation Policy/No Show Policy**

We’re glad you have chosen us to provide your medical care. If you miss your appointments, you compromise your care. We want to remind you of our office policies regarding missed appointments.

A missed appointment is when you fail to show up for an appointment without a phone call or cancel without prior notification.

We strive to be on time for your scheduled appointment and ask that you give us the courtesy of a call when you are unable to keep your appointment. We have outlined our missed appointment policies below.

**New Patient Consultations**

We require 48 business hour notice for all new patient appointment cancellations otherwise a **$250 no show fee** that is not covered by insurance will be charged.

**Follow-up Office Visits**

We require 24 business hour notice for all routine office visits otherwise a $50 no show fee will be charged.

**1st missed follow up appointment**: We’ll call and offer to reschedule your appointment. You may be charged a missed appointment fee of $50.

**2nd missed follow up appointment**: You will receive written notification of your missed appointment and will be charged a fee of $50.

**3rd missed follow up appointment**: You will be charged an additional missed appointment fee of $50. This may also result in a discharge from the practice.

**Late Policy:**

We allow a 15-minute grace period from your appointment start time. However, if you are late your appointment will be cut short to maintain clinic schedule. If you arrive after 15-minutes from the start of your appointment, you may not be seen and will be rescheduled.

**Term of Care:**

Our psychiatric providers have completed additional training to gain expertise in the management of psychiatric disorders across pregnancy and in the postpartum. To help provide our expertise to more patients, we may provide time-limited clinical care while you are pregnant and up to one year postpartum. At one year postpartum, we will help provide referrals to help you transition your care to a general psychiatrist, therapist, or primary care doctor (as deemed appropriate). We are also happy to act as consultants to your treating providers (in which case they will be prescribing your medications) during pregnancy and up to one year postpartum.

By signing below you are indicating that you have read and are in agreement with our clinic policies and terms.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_