



ADVANCED PAIN CENTERS

HOT FLASHES QUESTIONNAIRE

Please answer the following questions.

1. The name and telephone number of your primary care physician and/or your gynecologist.

2. Do you currently have “hot flashes? Yes No If yes, how often and what symptoms do you exhibit (ie, sweats, waking frequently at night, dizziness, etc.)?

3. Have you ever had an adverse reaction to any medication? If yes, please specify.

4. Please list all known allergies:

5. Please list all medications that you are currently taking and the dosage:

6. Please indicate which of the following applies:

MILD HOTFLASHES PER DAY : 0 1 2 3 4 5 6 7

MODERATE HOTFLASHES PER DAY: 0 1 2 3 4 5 6 7

SEVERE HOTFLASHES PER DAY: 0 1 2 3 4 5 6 7

VERY SEVERE HOTFLASHES PER DAY: 0 1 2 3 4 5 6 7

CURRENT NUMBER OF AWAKENINGS : 0 1 2 3 4 5 6 7

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6. Are you under the care of a specialist for cardiac or any other serious conditions? If yes, then please list the name of the specialist, phone number, and the nature of the care.

<u>Specialist Name</u>	<u>Phone #</u>	<u>Nature of Care</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Have you had any treatment for your hot flashes? If so, please list.

8. What is your goal in having this treatment. Please be specific:

Signature: _____ Date: _____

Printed Name: _____