



## **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.

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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.)?

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

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4. Please list all known allergies:

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

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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

Hot Flashes Questionnaire  
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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.

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\_\_\_\_\_  
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8. What is your goal in having this study. Please be specific:

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\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_