



For the latest women's health information visits our website on <http://womens.health.med.monash.edu.au>

The Women's Health Program at Monsh University is setting up a database for women who are interested in being contacted to participate in our research studies. Would you like to be contacted if we are conducting a clinical trial for which you may be eligible?

If so, please complete this form and either:

Fax it to us on: 03 9903 0828

Email to: womens.health@med.monash.edu.au

Or post to: Women's Helath Program  
Monash Medical School  
Alfred Hospital  
Commerical Road  
Prahran, Vic 3181

All information will remain confidential. The Women's Health Program will not make this information available to any other group or institution.

**If you have any queries please contact us on (03) 9903 0827**

Name: ..... Address: .....

Day time tel no: ..... .....

2nd Contact number: ..... .....

Height: ..... Post code: .....

Weight: .....

Email address: .....

**Which of the following studies would you like us to contact us about?  
(please tick as many boxes as applicable)**

Hot Flushes

Osteoporosis

Low libido

New forms of HRT

Depression

Other (please specify)

.....

**1. Do you have a past or current history of: (please tick as many boxes as is applicable)**

- |                                                                       |                                                 |
|-----------------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Liver Disease                                | <input type="checkbox"/> Deep Venous Thrombosis |
| <input type="checkbox"/> Low bone density (not osteoporosis)          | <input type="checkbox"/> Osteoporosis           |
| <input type="checkbox"/> Depression                                   | <input type="checkbox"/> High blood pressure    |
| <input type="checkbox"/> Gynaecological Cancer                        | <input type="checkbox"/> Past heart attack      |
| <input type="checkbox"/> High blood pressure.....                     | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Past stroke                                  |                                                 |
| <input type="checkbox"/> Other form of cancer: (please specify) ..... |                                                 |
| <input type="checkbox"/> Other serious illness (please specify) ..... |                                                 |
| <input type="checkbox"/> Any allergies (please specify) .....         |                                                 |

**2. Do you take: (please tick as many boxes as is applicable)**

- |                                                     |                                                          |
|-----------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Blood thinning medication  | <input type="checkbox"/> Cholesterol lowering medication |
| <input type="checkbox"/> Anti-convulsant medication | <input type="checkbox"/> Tamoxifen                       |
| <input type="checkbox"/> Steroids/Corisone          | <input type="checkbox"/> Blood Pressure Medication       |
| <input type="checkbox"/> Oral Contraceptive pill    | <input type="checkbox"/> Other: .....                    |

**3. Are you:**

- Premenopausal (still having regular periods)
- Perimenopausal (irregular periods or experiencing menopausal symptoms)
- Postmenopausal (no periods)

**4. Have you had:**

- |                                            |                                               |
|--------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> A hysterectomy    | <input type="checkbox"/> Both ovaries removed |
| <input type="checkbox"/> One ovary removed | <input type="checkbox"/> None of the above    |

**4. Do you suffer from: (please tick as many boxes as is applicable)**

- |                                                |                                         |                                    |
|------------------------------------------------|-----------------------------------------|------------------------------------|
| <input type="checkbox"/> Premenstrual syndrome | <input type="checkbox"/> Hot flushes    | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Night sweats          | <input type="checkbox"/> Loss of libido |                                    |
| <input type="checkbox"/> Depression            | <input type="checkbox"/> Mood swings    |                                    |

**5. Have you used menopausal hormone therapy?**

- Current                      Name of therapy used: .....
- In the past                      Name of therapy used: .....
- Never

**6. Have you used testosterone therapy?**

- |                                      |                              |                                    |
|--------------------------------------|------------------------------|------------------------------------|
| <input type="checkbox"/> Current     | Form of Testosterone therapy | <input type="checkbox"/> Injection |
| <input type="checkbox"/> In the past |                              | <input type="checkbox"/> Implant   |
| <input type="checkbox"/> Never       |                              | <input type="checkbox"/> Cream     |