



The Jean Hailes Foundation is setting up a database.

Would you like to be contacted if we were conducting a clinical trial for which you may be eligible? If so, please complete this form and return by mail or fax to the Foundation.

All information given will remain confidential. The Jean Hailes Foundation database will not be made available to any other group or institution. If you have any queries please phone us on 03 9543 9612.

<p>Mail The Jean Hailes Foundation Research Unit 173 Carinish Road Clayton Victoria 3168</p>	<p>Fax The Jean Hailes Foundation Research Unit 03 9543 9609.</p>
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Name..... **Address**.....

Phone No.....

.....

Date of Birth..... **Post Code**.....

Height.....(cm)

Weight.....(kg)

<u>Past History of:</u> (tick appropriate box)		
	Yes	No
Bone Fracture	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Other Type of Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Deep Venous Thrombosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Low Bone Density (not osteoporosis)	<input type="checkbox"/>	<input type="checkbox"/>

<u>Do You Take:</u> (tick if appropriate)	
Blood Thinning Medication	<input type="checkbox"/>
Cholesterol Lowering Medication	<input type="checkbox"/>
Anti-Convulsant Medication	<input type="checkbox"/>
Tamoxifen	<input type="checkbox"/>
Steroids/Cortisone	<input type="checkbox"/>
Anti-Depressants	<input type="checkbox"/>
Anti-Hypertensives	<input type="checkbox"/>

Are You :-
(tick appropriate box)

Pre-menopausal

Menopausal
(with regular or irregular periods)

Post-Menopausal

Have You Had :-
(tick if appropriate)

Hysterectomy

Both Ovaries Removed

One Ovary Removed

Do You Suffer From :-
(tick appropriate box)

	Yes	No
Pre-menstrual Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Libido	<input type="checkbox"/>	<input type="checkbox"/>
Depression / Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>

Have You Used Estrogen Replacement Therapy (HRT)
(tick appropriate box)

<input type="checkbox"/> Current	Form of HRT :-	tablet <input type="checkbox"/>
		implant <input type="checkbox"/>
		cream <input type="checkbox"/>
<input type="checkbox"/> In the past		
<input type="checkbox"/> Never		

Have You Used Testosterone Replacement Therapy
(tick appropriate box)

<input type="checkbox"/> Current	Form :-	injection <input type="checkbox"/>
		implant <input type="checkbox"/>
		cream <input type="checkbox"/>
<input type="checkbox"/> In the Past		
<input type="checkbox"/> Never		

Thank you for your assistance