**Patient Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **D.O.B.:**\_\_\_\_\_\_\_\_

|  |
| --- |
| **IS THERE A SPECIFIC TOPIC YOU WOULD LIKE TO DISCUSS WITH YOUR DOCTOR TODAY? -** *(please tick)* |

Contraception advice  Bladder problems  Menopause

Fertility issues  Relationship issues  Breast Concerns

Pregnancy  Mental Health  Sexual Health

Period concerns  Cervical Screening Test  Other

|  |
| --- |
| **ALLERGIES –** *please include ALL allergies.* |

**Do you have any allergies?**  YES NO

|  |  |
| --- | --- |
| **Allergy** | **Reaction** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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## PAST MEDICAL HISTORY

**Please outline any past medical problems/hospital admissions or surgery:**

**Year Details**

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

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**CURRENT MEDICATIONS –** *Please include all tablets, inhalers, patches, gels or injections. Please also include any natural remedies such as vitamins, herbals, homeopathic remedies and supplements.*

**Name of Medication and Dose**:

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

|  |
| --- |
| **MENSTRUAL HISTORY** |

**Not applicable**

**What was the age of your first period?** \_\_\_\_\_\_\_\_\_\_

**What is the length of your period/bleeding** \_\_\_\_\_\_\_\_\_\_ Days/ Months

**What is the length of your menstrual cycle?** \_\_\_\_\_\_\_\_\_\_Days/ Months

**Do you experience any of the following?**

|  |  |
| --- | --- |
| **Bleeding outside of your period?** |  |
| **Bleeding or pain with intercourse?** |  |
| **Painful periods?** |  |
| **Heavy periods?** |  |
| **Prolonged periods?** |  |

**Please note any further details relating to your menstrual cycle:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **CONTRACEPTION HISTORY** |

**Are you currently taking any form of contraception? YES NO**

**If yes, current form of contraception: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Year started: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

## PREGNANCY HISTORY

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Year** | **Delivery method** | | | |
|  | **Vaginal** | **Caesarean** | **Miscarriage** | **Termination** |
|  | **Vaginal** | **Caesarean** | **Miscarriage** | **Termination** |
|  | **Vaginal** | **Caesarean** | **Miscarriage** | **Termination** |
|  | **Vaginal** | **Caesarean** | **Miscarriage** | **Termination** |
|  | **Vaginal** | **Caesarean** | **Miscarriage** | **Termination** |

**Please note any complications related to pregnancy or birthing:**

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

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## PREVENTATIVE HEALTH SCREEN

**What year was your last Cervical Screening Test/Pap Smear?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Was this Normal or Abnormal?** Normal Abnormal

**What year was your last Mammogram?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What year was your last bone density?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Result/ Recommended follow up:**

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

**What year was your last Bowel Cancer Screen?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Result/ Recommended follow up:**

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

**MUNISATION HISTORY** *(please tick)*

**FAMILY HISTORY** – *Please advise if any of your close family (parents/siblings/children) have suffered from any of the following health issues/ concerns:*

|  |  |  |  |
| --- | --- | --- | --- |
| Disease | Relative | Disease | Relative |
| Heart attack |  | Breast cancer |  |
| Arthritis |  | Blood clots |  |
| Stroke |  | Thyroid disease |  |
| Diabetes |  | Osteoporosis |  |
| Ovarian cancer |  | Thyroid disease |  |
| Mental health |  | Other: | |
|  | | | |
|  | | | |
|  | | | |

|  |
| --- |
| **LIFESTYLE HISTORY** |

**Do you currently smoke cigarettes/ vape? YES NO**

**Have you smoked or vaped in the past? YES NO**

**How many cigarettes are you smoking per day/ vape puffs per day?** \_\_\_\_\_\_\_

**What year did you start smoking/vaping?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What year did you stop smoking/vaping? (if previously quit)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you drink alcohol?** Yes No

**How many days per week would you consume: \_\_\_\_\_ days/week**

**How many drinks when consuming?** \_\_\_\_\_\_**drinks/day**

**I currently exercise:** Daily Weekly Occasionally Never

**Do you follow a specific diet?** Yes No

**If *yes,* please provide details (i.e. Keto, Vegan, Vegetarian)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****

**In your *CURRENT* relationship/ marriage are you: Yes No**

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Afraid for your safety or hold a fear of being harmed?

Do you experience any verbal, physical or financial abuse?

**In your *PAST* relationships/ marriage have you ever:**

Been afraid for your safety or scared of being harmed?

Have you experienced verbal, physical or financial abuse?

**Do you have a history of childhood trauma?**

Do you want to seek help for any of these issues raised today?

If you are wishing to discuss ***Menopause/ Menopause Hormone Therapy*** with your GP today, please kindly complete the next page of this form.

Otherwise, we thank you for taking the time to complete our Medical Questionnaire Form. Please take this form with you when you are called by your GP.

**MENOPAUSE SYMPTOM CHECKER –** *Please use the below symptom checker to indicate the severity of your symptoms.*

**Symptom Mild Moderate Severe**

Hot flushes

Light headed

Headaches

Irritability

Depression

Unloved feelings

Anxiety

Mood changes

Sleeplessness

Unusual tiredness

Backache

Joint pains

Muscle pains

New facial hair

Dry skin

Skin crawling

Less sexual feeling

Dry Vagina

Uncomfortable intercourse

Urinary frequency

Weight gain

**How are you currently managing your menopause symptoms?**

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

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**Are you currently taking any HRT medications?** Yes No

**Please provide name of medication:**

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

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**Thank you for completing this questionnaire. Warm regards - Sirona Women’s Health**