Women's Health Clinic. Introductory Questionnaire

Please answer the following questions which will your doctor to individualise your check up.

All information provided remains completely confidential.

Name:

Address:

Date of birth:

General Lifestyle Questions

Do you smoke? ☐ Yes ☐ No ☐ Previously

How often do you drink alcohol?

☐ Daily ☐ 1-2 Times a week ☐ 3-4 Times a week

☐ Weekly ☐ Monthly

How often do you exercise?

☐ Daily ☐ 1-2 Times a week ☐ 3-4 Times a week

☐ Weekly ☐ Monthly

What type of exercise do you take?

☐ Walking ☐ Running ☐ Golf ☐ Gym ☐ Other _____

How many portions for fruit/vegetables do you eat per day?

☐ 0 ☐ 1 - 2 ☐ 3 - 4 ☐ 4 - 5 ☐ More than 5

How many portions of sweets, cakes, chocolates, and biscuits do you eat per day?

☐ 0 ☐ 1 - 2 ☐ 3 - 4 ☐ 4 -5 ☐ More than 5

Do you feel stressed due to your work, home life or financial pressures?

Yes ☐ No ☐ Intermittently ☐ Regularly ☐

Medical History

Have you ever suffered from? (Please tick relevant boxes)

☐ Heart attack or Angina

☐ Rheumatic Fever

☐ High Blood Pressure

☐ High Cholesterol

☐ Asthma

☐ Bronchitis / Emphysema

☐ Cancer Please specify type _____

☐ Thyroid Disorder

☐ Allergies

☐ Migraine

☐ Blackouts / Seizures

☐ Stroke / Mini – stroke

If you have a family history of any of the conditions above, please provide details below

If you have ever been hospitalised in the past or had any operations, please provide details below

Please list any medication that you are currently being prescribed or taking as over the counter treatments such as herbal remedies

Female Wellbeing

Have you ever had a cervical smear test? Yes ☐ No ☐

If yes was your most recent one normal? Yes ☐ No ☐

Are you registered with Cervical Check programme? Yes ☐ No ☐ Don't know ☐

Do you regularly examine your Breasts? Yes ☐ No ☐

Have you ever noticed any lumps or swelling in your breasts? Yes ☐ No ☐

Have you ever had a mammogram? Yes ☐ No ☐

If yes was your most recent one normal? Yes ☐ No ☐

Are you registered with Breast Check programme? Yes ☐ No ☐ Don't know ☐

When was your last period? _____

Have you ever been pregnant? Yes ☐ No ☐ If yes how many times _____

How many children or births have you had? _____

Are you currently using contraception? Yes ☐ No ☐

If yes what type _____

Are you concerned about menopausal symptoms? Yes ☐ No ☐

Are your periods irregular, particularly painful or heavy? Yes ☐ No ☐ Not applicable ☐

Have you experienced any vaginal bleeding that you think is abnormal? Yes ☐ No ☐

Do you ever have difficulty controlling your bladder / getting to the toilet in time? Yes ☐ No ☐

Would you like to discuss anything related to sexual health or infertility? Yes ☐ No ☐

General Health

Is there any other aspect of your health that you would like to discuss? Yes ☐ No ☐

If yes, please provide details below

Please give your completed questionnaire to your doctor

Thank You