



Women's Wellbeing

CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

Once completed, please hand this multi-page questionnaire directly to your Doctor.

If there are any sections you prefer not to answer, feel free to leave them blank.

Patient name: _____

Age: _____

Which topics do you wish to discuss with your doctor today?

(Place a tick in the box next to the topic)

- Contraception
- Fertility Issues
- Pregnancy
- Period problems
- Pap smear
- Breast Concerns
- Other: _____

- Bladder Problems
- Infection worries
- Relationship issues
- Sexual difficulties
- Menopause (If yes please complete the symptom questionnaire on page 4)

Which of these is the most important? _____

What outcome would you like to achieve by the end of your consultation today?

Menstrual History

Age at menarche (first period) _____

Current length of period (days) _____

Current length of cycle (eg monthly, every 23 days) _____

Have you had any bleeding outside of your normal period?

Have you had any bleeding after sex?

Heavy? YES / NO

Painful? YES / NO

YES / NO

YES / NO

Pregnancies – Please include all pregnancies

Year	Normal delivery	Forceps	Caesarean Section	Other Outcome – Details (eg miscarriage/termination)

Contraception: Current _____
Past _____

Preventative Health

When was your last Pap smear taken? _____ Normal / Abnormal

If you have ever had an abnormal Pap smear, please give details: _____

When was your last Mammogram? _____ Result: _____

When was your last Bone density scan? _____ Result: _____

When was your last screening test for Bowel Cancer? _____ Result: _____

Have you received immunisation against the following diseases?

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Flu | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> HPV Virus (eg Gardasil, Cervarix) | <input type="checkbox"/> Hep B |
| <input type="checkbox"/> Hep A | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Meningococcal Disease |

Past Medical History

Have you suffered from any of the following - Currently or in the past?

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Anxiety or depression | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Glandular Fever | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Asthma | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fracture |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cancer |

Please list current and past serious illnesses, operations, hospital admissions, (if none write Nil)

Year	Details

Current medication:

Please include ALL tablets, inhalers, patches, gels or injections – As well as the pill and any 'natural' remedies such as vitamins, herbal remedies, homeopathic remedies & supplements

Name of Medication	Dose (if known)

Allergies:

Do you have any allergies – in particular to medications?

Allergy	Reaction

Family History

Has anyone in your close family suffered from the following?

(Please include the Relative affected eg: Mother, Sister etc)

Disease	Relative Affected	Disease	Relative affected
Heart attack		Bowel cancer	
High blood pressure		Ovarian cancer	
Stroke		Cancer of the cervix	
Blood clot(s)		Cancer of the Uterus	
Diabetes		Any other cancer	
Thyroid disease		Arthritis	
Osteoporosis		Depression	
Breast Cancer		Schizophrenia	
Other:			

Social History

Occupation: _____ Marital Status: _____

Heterosexual Homosexual Bisexual

Lifestyle

	Number per day	Number in the past	Quit Date
Smoker / Non Smoker / Ex-Smoker (Please circle your answer)			
Alcohol			
Other drug use			Type: _____

Recreational

Exercise:

What type of exercise do you do? _____

Duration & Frequency of exercise _____

Relaxation / Stress Management:

Do you practice meditation, yoga, tai chi or other? _____

Diet:

Do you follow a specific type of diet? _____ YES/NO

If yes, please specify (e.g. vegetarian, gluten free, low fat) _____

Does your diet include the following?

	YES / NO	Serves per day	OR	Serves per week
Cereals	YES / NO			
Dairy	YES / NO			
Red Meat	YES / NO			
White Meat	YES / NO			
Fish	YES / NO			
Green Leafy Veg	YES / NO			
Fruit	YES / NO			
Soft Drink	YES / NO			
Take-aways	YES / NO			
Tea	YES / NO			
Coffee	YES / NO			

Thank you for completing the questionnaire. Please hand directly to your Doctor.

Managing Midlife & Menopause

If you are wishing to discuss midlife issues, please complete the symptom box below:
(Place a tick next to the symptom to indicate the severity of the symptom)

Symptom	Mild	Moderate	Severe
Hot flushes			
Light headed feelings			
Headaches			
Irritability			
Depression			
Unloved feelings			
Anxiety			
Mood changes			
Sleeplessness			
Unusual tiredness			
Backache			
Joint pains			
Muscle Pains			
New facial hair			
Dry skin			
Crawling feelings under skin			
Less sexual feelings			
Dry vagina			
Uncomfortable intercourse			
Urinary frequency			
Memory loss			

Current Treatment:

Past use of HRT:

Natural Remedies:

Lifestyle Factors (e.g. work / family balance):

Diet:

Exercise:

Stress Management:
