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GYNAECOLOGY PATIENT QUESTIONNAIRE

This questionnaire allows more efficiency to spend quality time engaging and making individualised, holistic health care for you. Please provide a copy of any previous Pelvic Ultrasound Scans or Pathology results prior to, or on the day of your initial appointment.

First Name _____ Surname _____
Contact number _____ Email _____

Please outline your main women's health related concerns that I can help you with _____

_____

Please list any allergies you are aware of and reaction that occurs when exposed:

_____

_____

_____

MENSTRUAL HISTORY:

How old were you when your first period started? _____

Date your last period began: _____ How many days do your periods last? _____

How long is your cycle? (e.g., 28 days, less than 28 days) _____

SEXUAL HISTORY:

What contraception, if any, are you currently using? For how long? _____

_____

What contraception options, if any, have you used in the past? _____

_____

Are you currently sexually active? Yes ☐ No ☐

Do you experience any bleeding after sexual intercourse? Yes ☐ No ☐

Do you experience any excessive pain during sexual intercourse? Yes ☐ No ☐

If yes, how would you describe this pain on a scale from 1 to 10?

1 2 3 4 5 6 7 8 9 10

Mild Pain *Moderate Pain* *Severe Pain*

Do you have any current or previous history of sexually transmitted diseases? Yes ☐ No ☐

If **YES**, please provide detail _____

Are there any other sexual dysfunctions/ any issues related to sex?

_____

PREGNANCY HISTORY:

Please let us know of any previous pregnancy history including abortions & miscarriages

_____

Birthplace and Date	**Gestation**	**Type of Birth/ Model of Care** e.g., Midwife, Public/Private Obstetrician	**Birth Weight**	**If applicable: Name/Sex of child**

PAST MEDICAL HISTORY: Have you ever been diagnosed with any of the following: ☐

- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Depression
- ☐ Anxiety
- ☐ Other_____

If you answered **YES** to any of the above, please provide detail (i.e., date of diagnosis, outcome of diagnosis, type of cancer if applicable):_____

_____

_____

FAMILY HISTORY:

Has anyone in your immediate family been diagnosed with any of the following: None ☐

- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Other_____

If you answered **YES** to any of the above, please provide detail (i.e., date of diagnosis, outcome of diagnosis, type of cancer if applicable):_____

_____

_____

PAST SURGICAL HISTORY: Please list details of previous operations

Year	Place of surgery	Details of Surgery e.g., Doctor/type of surgery/any complications or issues?

MENOPAUSE:

Are you currently experiencing any of the following perimenopause or menopausal symptoms? No ☐

- ☐ Hot flushes
- ☐ Night sweats
- ☐ Headaches
- ☐ Irritability
- ☐ Depression and/or anxiety
- ☐ Unusual tiredness
- ☐ Joint or muscle pains
- ☐ Skin or vaginal dryness
- ☐ Reduced libido
- ☐ Uncomfortable intercourse
- ☐ Increased urinary frequency

If **YES**, please provide detail _____

CERVICAL SCREENING:

When was your most recent cervical screening test and what was the result? _____

Any past abnormal Cervical screening test? Please provide details: _____

Please provide a copy of your most recent cervical screening test results or bring a copy of these results with you on the day of your appointment.

ADDITIONAL QUESTIONS

Do you have any previous history of pelvic infection? Yes ☐ No ☐

Do you experience any pelvic pain? Yes ☐ No ☐

If yes, how would you describe this pain on a scale from 1 to 10?

1	2	3	4	5	6	7	8	9	10
Mild Pain				*Moderate Pain*				*Severe Pain*	

Have you noticed any abnormal vaginal discharge? Yes ☐ No ☐

If **YES**, please provide detail _____

_____

Do you currently have any urinary and/or bowel related concerns? Yes ☐ No ☐

If **YES**, please provide detail (i.e. Motion of passing/ Any incontinence issues/ etc…)

_____

What is your weight? _____ kg

What is your height? _____ cm

SOCIAL HISTORY:

Are you currently studying? Yes ☐ No ☐

If **YES,** please provide detail (e.g., course/institution/full- or part-time)

_____

Are you currently working? Yes ☐ No ☐

If **YES,** please provide detail (e.g., full- or part-time, occupation)

_____

Do you currently have a partner(s)? Yes ☐ No ☐

If you are comfortable to share, what is your partner(s) name? _____

Do you currently smoke? Yes ☐ No ☐

Do you take any recreational drugs? Yes ☐ No ☐

Do you identify as Aboriginal or Torres Strait Islander? Yes ☐ No ☐

_____