



DR. TANUSHREE

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SCAN ME

Gynaecological Questionnaire

Patient Information

Name: _____ Date of Birth: _____

Presenting Complaint: _____

Menstrual History:

Previous cycles: Regular Irregular

Last Pap smear: Date: _____ Normal Abnormal

Contraception: _____

Obstetric History:

Number of children: _____

Route of delivery: Vaginal Cesarean



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Medical Issues: _____

Anxiety Issues: _____

Prior Surgeries on Abdomen: _____

Family History of Genital Cancers: _____

Social Hx:

Occupation?

Do you smoke? Yes No

Do you drink alcohol? Yes No

Are you currently sexually active? Yes No

When was your last sexually transmitted infection screen? _____

Please provide any additional information you feel is relevant to your gynaecological health: _____