

**WOMEN'S HEALTH CHECK QUESTIONNAIRE**



FULL NAME: \_\_\_\_\_ | DATE OF BIRTH: \_\_\_\_\_ |

<i>Please tick where necessary for the following symptoms:</i>	<b>YES</b>	<b>NO</b>
<b>NERVOUS SYSTEM:</b>		
Hearing loss		
Vision Change		
Headache		
Fits/Faints		
Limb Weakness		
Limb Numbness		
Speech Change		
Incoordination		
<b>CARDIOVASCULAR SYSTEM:</b>		
Chest pain		
Shortness of breath		
Ankle swelling		
Palpitations		
Calf pain when walking		
Difficulty breathing at night or laying down		
<b>GASTRIC SYMPTOMS:</b>		
Indigestion		
Difficulty swallowing		
Vomiting		
Blood in vomit		
Weight loss		
<b>BOWEL SYMPTOMS:</b>		
Change bowel habit		
Loss of appetite		
Abdominal pain		
Blood from rectum or in bowel motions		

<i>Please tick where necessary for the following symptoms:</i>	<b>YES</b>	<b>NO</b>
<b>RESPIRATORY SYMPTOMS:</b>		
Cough		
Phlegm		
Coughing up blood		
Wheeze		
<b>UROLOGICAL SYMPTOMS:</b>		
Increase urine frequency		
Urinating at night		
Urge to pass urine often		
Incontinence		
Concern about sexual health		
<b>GYNAECOLOGICAL &amp; BREAST SYMPTOMS:</b>		
Current contraception		
Previous pregnancies		
Regular cycle		
Unscheduled vaginal bleed		
Vaginal irritation/discharge		
Recent breast change/lumps		
<b>MOOD SYMPTOMS:</b>		
Poor sleep		
Lack of enjoyment		
Anxiousness		
Depressed		
Irritability		
Poor concentration		

Please also complete the following section found on the next page. If you have a problem answering any questions on this form bring this up in consultation with your Doctor today.

<b>Last Menstrual Period:</b>			
<b>Date of Last Pap Smear:</b>			
<b>Date of Last Mammogram:</b>			
<b>Significant Medical History:</b>			
<b>Family History of Health Problems:</b>			
<b>Average Alcohol Weekly Intake:</b>	Beer	Spirit	Wine
<b>Please tick your Smoking Status:</b>	Never Smoked	Ex Smoker	Smoke Currently
<b>Allergies/Adverse Reactions to Medication:</b>	Recreational Drugs		
<b>List of Current Medications:</b>			

<i>Please tick where necessary for the following symptoms:</i>	<b>YES</b>	<b>NO</b>
<b>MISCELLANEOUS:</b>		
Previous mole mapping		
Any skin lesions of concern today?		
Do you see any Specialist doctors?		
Do you see any Allied Health Professionals? – Podiatrist/Physio etc		
Do you feel you are up to date with vaccinations?		

<i>Please tick where necessary for the following symptoms:</i>	<b>YES</b>	<b>NO</b>
<b>MISCELLANEOUS:</b>		
Are you a carer for someone?		
Do you want a medication review?		
Have you had a previous Bone density scan?		
Have you been to an Optometrist recently (12 months)		

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_.