Female Screening Questionnaire (Gynaecology)



Forms Administration AF1.34

Name			DOB (dd/mm	/уууу)				
Address				<u> </u>				
Brief desci	ription of your problem?							
Menstrual History								
How many days is your menstrual cycle (i.e. from start of one period to the start of next one)?								
Date of last menstrual period?								
For how many days do you bleed?								
Cervical Smear								
Have you ever had an abnormal smear?								
If yes, did you need treatment?								
If yes, please give details:								
Previous	Fertility Treatment Detail	s						
Have you	ever had fertility treatment		☐ Yes	□ No				
If Yes, please give brief details and bring any paperwork you may have to your consultation								
, μ	and give and a	9) ۲-۲	,	, ,				
Previous Pregnancy Details								
Body Mass Index								
What is yo	ur height (<i>in cms</i>)?		What is your	current weigh	nt (<i>in kgs</i>)?			

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Medical History								
(Include surgery,/operations, childhood problems, medical conditions e.g. asthma infections)								
Current medications								
Allergies to medications								
Family History								
(Include history of serious medical conditions which may be hereditary)								
Lifestyle								
Cigarettes per day		Average weekly alcohol intake (units) (I unit = ½ pint beer, 1 small glass wine)						
Average weekly exercise unde								
Do you have any significant stresses in your life?								
If Yes, please provide details								
Is there any other information you think we should know e.g. Religious/Ethical concerns?								
If Yes, please provide details								
Signed		Date						

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