

## WOMEN'S QUESTIONNAIRE

### PERSONAL DETAILS:

Date of consultation: \_\_\_ / \_\_\_ / \_\_\_

Surname: \_\_\_\_\_ Forenames: \_\_\_\_\_

### MENSTRUATION:

If menopausal, please also complete this stating what your menstrual cycles were like.

1. Age at onset: \_\_\_\_\_

2. Are your periods regular? \_\_\_\_\_

If NO please give details: \_\_\_\_\_

3. Length of cycle (in days) \_\_\_\_\_ e.g. 4 – 5 / 28 (4 – 5 days bleed every 28 days)

4. Are your periods heavy? \_\_\_\_\_

5. Are your periods light? \_\_\_\_\_

6. Do you get pre-menstrual tensions? \_\_\_\_\_

If YES please tick the relevant symptom(s) listed below:

Fluid retention

Headache

Breast tenderness

Depression

Bloating

Irritability

Carbohydrate craving

Weepiness

Fatigue

Mood swings

Other: \_\_\_\_\_

### MENOPAUSE:

1. Age of menopause? \_\_\_\_\_

2. Have you had a hysterectomy? YES / NO If YES state at what age: \_\_\_\_\_

3. Reasons for having hysterectomy: \_\_\_\_\_

4. Are you on hormone replacement therapy? \_\_\_\_\_

### GENERAL HEALTH:

1. Do you suffer from symptoms of dry vagina? YES/ NO

2. Are you aware of any thinning of your pubic and/or under arm hair? YES/ NO

**OBSTETRIC HISTORY:**

1. Have you ever had any terminations (abortions)? YES / NO

If YES please enter dates (month and year): YES / NO

2. Have you ever had any miscarriages? YES / NO

If YES please enter dates (month and year)

3. Do you have children? If YES please complete the sections below:

Year	Sex	Major problems during pregnancy/delivery if any:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**CONTRACEPTION:**

1. Are you currently sexually active? YES / NO

If YES what form of contraception do you currently use? \_\_\_\_\_

2. Have you been on the Pill in the past? YES / NO

If YES please state approx. when and for how long: \_\_\_\_\_

**TESTS:**

1. Date (month and year) of last breast examination: \_\_\_\_\_

2. Date (month and year) of last cervical smear: \_\_\_\_\_

3. Have you had any abnormal smear results in the past? If YES please give details and treatment: \_\_\_\_\_

**MEDICAL PROBLEMS:**

1. Do you have any breast problems? YES / NO

If YES please give details: \_\_\_\_\_

2. Do you have any sexual problems? YES / NO

If YES please discuss these at your consultation

3. Are there any other relevant problems/conditions that your doctor should be aware of?

If YES please give details: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**THANK YOU FOR COMPLETING THIS QUESTIONNAIRE**