

DATE.....

FILE NO.....

PATIENT NAME: .....SURNAME.....AGE: .....  
OCCUPATION: .....MARITAL STATUS.....

PARTNER NAME: ..... SURNAME.....AGE.....  
PARTNER OCCUPATION: .....

MAIN COMPLAINTS: 1.....  
2.....  
3.....

INFERTILITY: Do you suffer from infertility?.....IF YES, please complete the infertility questionnaire. (kindly request from receptionist)

REFERRAL

Have you been referred?.....By who?.....Medical Practitioner.....  
Friend or Family member.....Internet.....Self.....  
Have you consulted a doctor in the past 6 months?.....  
Have you had any blood tests done in the past 6 months?.....  
When?.....Which Lab?.....  
Did you have any other Special examinations? (Example: Mammogram,DXA?) .....  
If "Yes" please specify dates: .....

Are you currently Pregnant?.....

CONTRACEPTION: Are you sexually active?.....  
What contraception do you use?.....

PREGNANCIES: How many times have you become pregnant?.....  
Have you ever had any – cesarean sections?.....  
- miscarriages/abortions?.....  
- premature births (> 3 weeks early)?.....  
After your pregnancy did you – breastfeed?.....  
- suffer from depression?.....

| <u>Year of pregnancies</u> | <u>Male/Female</u> | <u>Method of Delivery</u> | <u>Gestation/duration of Pregnancies</u> | <u>Complications</u> |
|----------------------------|--------------------|---------------------------|--|----------------------|
|                            |                    |                           |  |                      |
|                            |                    |                           |  |                      |
|                            |                    |                           |  |                      |
|                            |                    |                           |  |                      |

PAP SMEAR: When was your last pap smear?.....  
Was it ever abnormal?.....

MENSTRUATION: At what age did your Menstruation start +/-?.....

LNM: When was your last normal menstruation?.....

DESCRIBE YOUR CYCLE: Regular.....Irregular.....Skip cycles?.....

Menstruate more than once/ month?.....

What was the the first day of your last period?.....

How many days does your menstrual flow last?.....

How would you describe your menstruation? Normal .....Heavy..... Light.....

DYSMENORRHEA: Do you have pain with your periods?.....

Little .....

Moderate .....

Severe .....

Do you need to take Pain medication?.....

DYSPAREUNIA: Do you have pain with intercourse?.....

If YES, please specify- Deep Pain ..... Vaginal Pain .....

ENDOCRINE:

Do you suffer from: - hot flushes?.....

- eating disorder?.....

- sleep abnormality?.....

- depression?.....

- headaches?.....

- Vision disturbance?.....

OTHER GYN HISTORY: Does your breasts leak?.....

Is the hair on your face, breasts or abdomen increasing?.....

Acne -Face..... Back.....

DO YOU SUFFER FROM INFECTION:?

Vaginal?.....Itching.....Burning.....

Odor.....Discharge.....

Have you ever had- sexually transmitted disease?.....

When was your last HIV test done?.....

URINARY SYSTEM

Do you suffer from urinary infections?.....

Do you have urine leak?.....

If yes: Does it cause embarrassment? .....Leak when cough/Laugh/Jump?.....

Leak before you reach the toilet?.....Do you have to go frequently?.....

How many times do you wake up at night to go to the toilet?.....

Do you have a heavy feeling or a lump in the vagina?.....

**SURGERY:**

Have you had any Gynecological surgery?.....Specify.....

Do you still have your Appendix?.....

**LAPAROSCOPIC SURGERY**

[Reason if yes] .....

**OTHER SURGERY:** Have you had any other operations?.....

Please Specify.....

**PERSONAL MEDICAL HISTORY:** Do you suffer any serious medical conditions? (Please circle):

(Diabetes, Heart disease, High blood pressure, Liver problems, Jaundice, Migraine, Tuberculosis, Thyroid, Epilepsy, Congenital hyperlipidemia, Sickle cell disease etc.)

**FAMILY HISTORY:** Do you have a close family history of:

- breast cancer .....Who?  
Mother side.....  
Father side.....

- ovarian cancer?.....
- Endometriosis?.....
- Osteoporosis?.....

- Close Family members with: (Please circle)  
(Diabetes, Heart disease, High blood pressure, Liver problems, Jaundice, Migraine, Tuberculosis, Thyroid, Epilepsy, Congenital hyperlipidemia, Sickle cell disease etc.)

**TREATMENT:** Do you take daily medication?.....If YES, please elaborate.....

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- Do you take any Aspirin (Disprin and/or Grandpa etc.)?.....
- Do you take any NSAID (Voltaren and or Brufen etc.)?.....

**ALLERGIES:** Are you allergic to any drugs?.....

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**SOCIAL:** Do you smoke?.....

Stopped: When?.....

Do you use excessive alcohol?.....

Do you use any recreational drugs?.....

Exercise: - What type of exercise do you do?.....

- How many times a week?.....

BOWEL: Are your bowel movements regular/normal?.....Constipation? .....  
Loose stools?.....Blood in the stool?.....  
Hemorrhoids?.....Are you losing weight?.....

EXERCISE:  
What type of exercise do you do?.....  
How many times a week?.....

Would you like a **Chaperone to accompany you in the examination room?**.....

What religion/church are you attending?.....