 **Gynaecology form (Female patients only)**

Menses History

|  |  |
| --- | --- |
| Date last menses began  | dd/mm/yyyy |
| Is your menstrual cycle  | Regular |  |  |
|  | Irregular |  |
| How old where you when you had your first menstruation? |  |
| Menstrual cycle length (i.e. 26-30 days) |  |

Contraceptive history

|  |
| --- |
| Have you taken oral contraceptives? **Y/N** |
| For how long? |
| When did you stop? |

Pre-menstrual symptoms (PMS)

Please check all that apply

|  |  |
| --- | --- |
| Breast tenderness |  |
| Cramps |  |
| Acne |  |
| Change in bowel |  |
| Nausea |  |
| Headaches |  |
| Moodiness |  |
| Fatigue |  |
| Night sweats |  |
| Sleep disturbances |  |

|  |
| --- |
| Please list any other pre-menstrual symptoms |

Menses

|  |  |  |
| --- | --- | --- |
| Describe your flow | Heavy |  |
|  | Light |  |
|  | Average |  |
|  |  |
| Consistency of blood | Watery |  |
|  | Thick |  |
|  | Average |  |
|  | Clotty |  |
|  |  |
| Colour | Red |  |
|  | Dark red |  |
|  | Brown |  |
|  | Brown/red |  |
|  | Bright red |  |
|  |  |
| Do you experience any Spotting? | Y/N |
| For how many days? |  |
| Do you experience menstrual pain? | Y/N |
| Before menses, during or after? | Pain type? |  |
|  | Stabbing |  |
|  | Cramping |  |
|  | Dull |  |
|  | Heavy |  |
|  | On / off |
| What relieves the pain? |  |

Ovulation

|  |  |
| --- | --- |
| Do you ovulate on your own? | **Y/N** |
| What Day? |  |
| Ovulatory pain | **Y/N** |
| Mastitis | **Y/N** |
| Do you chart your cycle? | **Y/N** |
| BBT |  |  |
| Ovulation sticks |  |  |
| Saliva |  |  |
| Do you notice stretchy, clear, egg white, cervical mucus around ovulation? | **Y/N** |
| Do you experience vaginal discharge? | **Y/N** |
| **Colour** |  |
| White |  |  |
| Yellow |  |  |
| Green |  |  |
| Pinkish |  |  |
| Red |  |  |
| **Consistency** |  |
| Watery |  |  |
| Thin |  |  |
| Thick |  |  |
| Sticky |  |  |
| Odour |  |  |

|  |
| --- |
| Pregnancies |
| Births |

Menopause

|  |
| --- |
| Age started? |
| Age finished? |
| Symptoms |
| Medication (HRT/how long)? |

Please check if you have ever been diagnosed with

|  |  |
| --- | --- |
| An STD |  |
| Uterine fibroids |  |
| Pelvic adhesions |  |
| Unique shaped uterus |  |
| Polyps |  |
| Prolapsed uterus |  |
| Endometriosis |  |

|  |
| --- |
| If yes please provide details  |

|  |
| --- |
| Have you ever had an abnormal pap smear? (Date of last pap smear) **Y/N** |
| Have you ever had a cervical biopsy or operation? **Y/N**  |
| Do you get yeast infections regularly? **Y/N** |
| Have you had any hormone lab tests performed? (Test and level) **Y/N** |