Dr.Myran Ponnam-Palam FERTILITY SPECIALIST

MBBS BSc (Med) Hons DRACOG FRANZCOG MM
Male & Female Fertility and Gynaecology.

Confidential Gynaecology Patient Medical Questionnaire.

Answering the below questions accurately as possible will help us understand any issues that may be impacting your health. Please take your time answering all questions and return to reception.

Surname: _____ First Name:_____

Date of Birth: _____/_____/_____ Weight (kg):_____ Height (cm):_____

(Please circle)

Do you smoke? Yes / No How many cigarettes per day?_____

Do you drink alcohol? Regularly / Rarely / Never

Do you use recreational drugs? Yes / No If yes, please specify: _____

Have you lost or gained a lot of weight recently? Yes / No

Have you ever used contraception? Yes / No

If yes, please specify: Contraceptive Pill / Condoms /Intrauterine device / Other: _____

How long is your cycle? 25-27 days / 28-30 days / 31-35 days / 36+ days / irregular.

How many days does your period last? _____ At what age did you first get your period?_____

Is your period painful? Yes / No Do you feel the amount of blood loss is abnormal? Yes / No

Do you have a lot of symptoms prior to your period? Yes / No

Do you ever have spotting in between periods? Yes / No

Have you ever been pregnant? Yes / No If yes, when was your last pregnancy?_____

If yes, please specify how many pregnancies you have had below:

	Current Partner	Previous Partner (s)
Miscarriages		
Terminations of pregnancy		
Ectopic Pregnancies		
Live births		

Is intercourse painful? Yes / No Do you have a sexual partner? Yes /No

Do you have any concerns about your sexual activity you would may want to discuss with your doctor? Yes / No

When did you have your last Pap smear? _____ Have you had an abnormal Pap smear? Yes / No

If yes, how were you treated? _____

Please turn the page over →

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Confidential Gynaecology Patient Medical Questionnaire – continued.

(Please tick)

Do you have a known history of any of the following?

- ☐ Fibroids
- ☐ Polyps
- ☐ Ovarian Cysts
- ☐ Endometriosis

If so, please specify if these have been treated: _____

Have you ever had an operation?

	Year		Year
☐ Laparoscopy	_____.	☐ Tubal ligation	_____.
☐ Hysteroscopy	_____.	☐ Myomectomy	_____.
☐ Hysterectomy	_____.	☐ Removal of ovarian cyst	_____.
☐ D&C	_____.	☐ Bladder repair	_____.

☐ Other: _____

Have you recently had any of the following?

- ☐ Hair growth
- ☐ Hair loss
- ☐ Breast Discharge
- ☐ Change in urinary function
- ☐ Hot flushes / flashing
- ☐ Night Sweats
- ☐ Acne

Do you have any diseases that run in the family? Yes / No If yes, please specify:_____

_____

Are you currently on any medications? Yes / No If yes, please specify:_____

_____

Do you have any allergies? Yes / No If yes, please specify:_____

_____

Personal Remarks: _____

_____

I declare the above information to be complete and correct.

Signature:_____ Date: _____/_____/_____