Dr. Myuran Ponnam-Palam
FERTILITY SPECIALIST

Confidential Gynaecology Patient Medical Questionnaire

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

Surname: _____ First/Middle Name: _____

Date of Birth: ____/____/____ Height (CM): _____ Weight (KG): _____

(Please tick)

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 pregnancies		
Ectopic pregnancies		
Live births		

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

Do you have concerns about your sexual activity you 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 page over →

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(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? ☐ Yes ☐ No If yes, please specify:

	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: _____/_____/_____