

Well Woman Health Check

Please help our doctor by completing the following information about yourself and bringing a printed and completed form with you to your appointment.

Appointment Date: _____

About Yourself

Name _____ **Date of Birth** _____

Occupation _____ **Age** _____

Are there any specific questions or concerns about your health you would like answered?

Do you smoke? If so, how many a day? _____ **How many units of alcohol per day?** _____

Your Past and Current Medical Health *(leave question blank if answer is NO)*

Please advise us of any prior or current medical problems:

Please advise us of any surgical operations you may have had:

Please advise us if you have, or have had, any gynaecological problems:

Please let us know if you have ever been admitted to Hospital and why:

Please let us know if you have ever been referred to a specialist and for what reason:

Family Medical History *(Please note their state of health, age (if alive) or cause and age of death)*

Maternal Grandparents: _____

Paternal Grandparents: _____

Parents: _____

Brothers / Sisters: _____

PLEASE INFORM US OF ANY FAMILY HISTORY OF BREAST/OVARIAN CANCER. BRITTLE BONES OR EARLY HEART DISEASE

Obstetric

First day of your last menstrual period: _____ **Are you taking any medication:** _____

Date of your last cervical smear: _____ **Result of smear if known:** _____

Type of contraception used: _____ **Miscarriages/Terminations:** _____

If you have any children, when where they born, what sex are they and the type of delivery they had:
