NAME:.....AGE:.....SPOUSE NAME:.....

OCCUPATION:.....SPOUSE OCCUPATION:.....

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

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

Year of pregnancies	Male/Female	Method of Delivery	Gestation/duration of Pregnancies	Complications

Menstruation: What was the date of the first day of your last period?.....
Was it normal?.....cycle regular?.....
At what age did your Menstruation start +/-?.....

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

Dyspareunia: Do you have pain..... or bleeding..... with intercourse?.....

Infection: Vaginal?.....
Urinary?.....

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

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

PMS: Before your periods start, do you have breast discomfort?.....
- mood changes?..... - bloating?.....
Do these symptoms interfere with – personal relationships?.....
- your ability to function?.....

Other: Have you ever had a: – abnormal vaginal discharge?.....
- sexually transmitted disease?.....

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

Do you suffer from: - hot flushes?.....
- eating disorder?.....
- sleep abnormality?.....
- depression?.....
- headaches?.....

Gyn surgery: Have you had any Gynaecological surgery?.....

Surgery: Have you had any other operations?.....
Please Specify.....

Other Gyn history: Does your breasts leak?.....
Is the hair on your face, breasts or abdomen increasing?.....
Do you have a heavy feeling in the vagina?.....

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 hyperlipidaemia, Sickle cell disease etc.)

Family history: Do you have a close family history of:
- breast or ovarian cancer?.....
- Endometriosis?.....
- Osteoporosis?.....
- Do you have any Family history of: (Please circle)
(Diabetes, Heart disease, High blood pressure, Liver problems, Jaundice, Migraine, Tuberculosis, Thyroid, Epilepsy, Congenital hyperlipidaemia, Sickle cell disease etc.)

Treatment: Do you take daily medication?.....What?.....
.....
- 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?.....
.....

Social: Do you smoke?.....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?.....Are you losing weight?.....

Bladder: Do you have any problems with urination?.....
- burning?..... - frequent urination?.....
- does your urine leak?.....

Have you consulted a doctor in the past 6 months?.....
Have you had any blood tests done in the past 6 months?.....When?.....
Did you have any other Special examinations? (Example: Mammogram, DXA?).....
If "Yes" please specify dates:.....