GYNAECOLOGY QUESTIONAIRE

Full Circle
OBSTETRICS & GYNAECOLOGY

Title:	Dr		Mr		Mrs		Miss		Date of Birth:	
Surname:									Given Name:	

What is your main concern? Or please outline your current problem

What previous treatment or investigations of the problem(s) have you had?

MENSTRAL HISTORY:

At what age did you have your first menstrual period?					Date of first day of your last menstrual period?				
Menstrual cycle eg. 28 days?	Days				Regular				
How many days is your menstruation?	Days				Irregular				
Do you have any of the following symptoms?									
Bleeding after intercourse	Yes		No		Painful Period	Yes		No	
Intermenstrual Spotting	Yes		No		Heavy Period	Yes		No	
Have you used any form of contraception? If yes, please specify the type and period of use.									

GYNAECOLOGICAL HISTORY: *Conditions, Treatments, Timeline of diagnosis and treatment*

Year(s)	Symptoms	Diagnosis	Treatment

Date of last (CST) Cervical Screening Test					Screening Result	
Previous Abnormal CST	Yes		No		If yes, what year?	

Have you had the HPV (Cervical Cancer Vaccine) vaccination?				
Have you ever had a sexually transmitted disease screening (STI)?				
In the last 12 months have you had any of the following relevant to this visit?				
Blood Tests	Yes		No	
Radiology Tests including Ultrasound or Hysterosalpingogram	Yes		No	
Semen Analysis	Yes		No	
Have you been seen by other specialists? If yes, provide details below:	Yes		No	

PREGNANCY HISTORY: *Number of pregnancies including miscarriages, terminations, ectopic pregnancies, and deliveries.*

Year	Gestation (weeks)	Labor, Birth & Post Natal Details	Birth Weight	Gender	Breast/Bottle	Name

MEDICAL & SURGICAL DETAILS:

Year of Diagnosis	Medical Condition	Treatment including Surgeries	Complications including Anesthetic

MEDICATION HISTORY:

Medication	Dose	Frequency	Reason for taking and duration

**Allergies	Describe in detail the reaction

Do you smoke?	Yes		No		Drink Alcohol?	Yes		No	
Are you an ex-smoker?	Yes		No		If yes, standard drinks	per week			
Do you take recreational or illicit drugs?	Yes		No		Have you been exposed to hazardous materials?	Yes		No	
If yes, what type?					If yes, what materials?				

FAMILY HISTORY: *Including genetic disorders, cystic fibrosis, cancers, and blood/bleeding disorders.*

Person	Condition(s) or Disease(s)	Treatment(s)	Outcome

OTHER INFORMATION:

Other information you may wish to provide OR issues you may wish to address OR your expectations:

Remember to forward your completed New Patient Information Form and your completed Questionnaire back to us!
to enable Dr Preetam Ganu to review prior to your appointment.
by fax **08 8299 0893** or email flindersobgyn@gmail.com

JUST ONE MORE QUESTIONAIRE TO DO – SCROLL DOWN OR TURN OVER

DASS21

Full Circle
OBSTETRICS & GYNAECOLOGY

Patient Name:		Date:	

Please read each statement and circle a number 0, 1, 2 or 3 whichever indicated how much the statement applied to you over the past week (7 days) only.

There are no right or wrong answers. Do not spend too much time on any one statement.

The rating scale is as follows:

0 Did not apply to me at all.
1 Applied to me to some degree.
2 Applied to me to a considerable degree, or a good part of the time.
3 Applied to me very much, most of the time.

	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I could not seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (e.g., excessively rapid breathing and/or breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react of situations	0	1	2	3
7	I experienced trembling e.g., in the hands	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt downhearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I was not worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (e.g., racing heart rate, palpitations, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3