WELL WOMAN QUESTIONNAIRE

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Already a patient with us? Yes  No  if **No**, complete New Patient Form

Own Doctors name: Dr\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent to receive text/email results Yes  No 

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_

*To assist our GP during your upcoming Well Woman Health Review, please complete the questions below*

General Lifestyle Questions*(tick as appropriate)*

1. **Do you smoke?** Yes  No  Previously 
2. **If yes or previously, how many do (did) you smoke per day? \_\_\_\_\_\_\_\_\_\_**
3. **How often do you drink alcohol?**

Never  Daily  1-2 times per week 

3-4 times per week  Weekly  Monthly 

1. **How many standard drinks do you consume each week?** (1 standard drink = half pint beer or 1 glass wine 100ml or 1 pub measure of spirits 35.5ml) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Do you take illicit substances e.g. Cannabis, Cocaine?** Yes No 
3. **How often do you exercise?**

Daily  1-2 Times a week  2-3 Times a week

 Weekly  Monthly 

1. **What type of exercise do you take?**

Walking  Running  Golf  Gym  Other

1. **How many portions of fruit/vegetables do you eat per day?**

0  1  2- 3  3 - 4  4 - 5  More than 5 

1. **How many portions of sweets, cakes, chocolates, and biscuits do you eat per day?**

0  1  2- 3  3 - 4  4 -5  More than 5 

1. **Do you feel stressed due to your work, home life or financial pressures?**

Yes  No  Intermittently  Regularly 

## Medical History

1. **Do you experience any of the following symptoms?**
   1. Chest pain 
   2. Shortness of breath 
   3. Palpitations 
   4. Cough 
   5. Abdominal pain 
   6. Change in bowel habit 
   7. Problems passing urine 
   8. Blood when you go to the toilet 
   9. Headaches 
   10. Joint pains, neck or back pain 
   11. Difficulty sleeping 
   12. Difficulty concentrating, low mood or feeling anxious 
   13. Unexplained weight loss 
   14. Nightsweats 
2. **Have you ever suffered from? (Please tick relevant boxes)** 
   1. Heart attack or Angina 
   2. Rheumatic Fever 
   3. High Blood Pressure 
   4. High Cholesterol 
   5. Asthma 
   6. Bronchitis / Emphysema 
   7. Cancer Please specify type 
   8. Thyroid Disorder 
   9. Allergies 
   10. Migraine 
   11. Blackouts / Seizures 
   12. Stroke / Mini – stroke 
   13. Back Pain 
   14. Depression 
   15. Anxiety 
   16. Osteoporosis 
   17. Diabetes 
3. **If you have a family history of any of the conditions above, please provide details below**

1. **Have you ever been hospitalised in the past or had any operations, please provide details below:**

1. **List your current medications including contraception:**

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## Female Wellbeing

Have you ever had a cervical smear test? Yes  No 

Have you had any abnormalities on your smear? Yes  No 

Have you been vaccinated against Cervical cancer? Yes  No 

Are you registered with Cervical Check programme? Yes  No  Don’t know 

Do you regularly examine your Breasts? Yes  No 

Have you ever noticed any lumps or swelling in your breasts? Yes  No 

Have you ever had a mammogram? Yes  No 

If yes was your most recent one normal? Yes  No 

Is there a family history of breast, ovarian or womb cancer? Yes  No 

Are you registered with Breast Check programme? Yes  No  Don’t know 

Are you concerned about menopausal symptoms? Yes  No 

Are your periods irregular, particularly painful or heavy? Yes  No  N/A 

Are you trying to conceive? Yes  No 

Have you experienced any vaginal bleeding that you think is abnormal? Yes  No 

Do you have any vaginal discharge that concerns you? Yes  No 

Do you ever have difficulty controlling your bladder / getting to the toilet in time? Yes  No 

Have you ever fractured a bone? Yes  No 

Have you ever been tested for osteoporosis? Yes  No 

## **Would you like to discuss anything related to sexual health or infertility?** Yes  No 

## General Health

**Is there any other aspect of your health that you would like to discuss?** Yes  No 

If yes, please provide details below

To protect your confidentiality, please insert this questionnaire into the envelope provided, seal it and give to your HR administrator for return to us.

Thank You