# GYNAECOLOGY QUESTIONAIRE

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

| What is your main concern? Or please outline your current problem |
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| What previous treatment or investigations of the problem(s) have you had? |
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## 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. | | | | | | | |
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## GYNAECOLOGICAL HISTORY: Conditions, Treatments, Timeline of diagnosis and treatment

| Year(s) | Symptoms | Diagnosis | Treatment |
|---|---|---|---|
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| Date of last (CST)<br>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 | Place | Gestation (weeks) | Labor, Birth & Post Natal Details | Birth Weight | Gender | Breast/Bottle | Name |
|---|---|---|---|---|---|---|---|
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**MEDICAL & SURGICAL DETAILS:**

| Year of Diagnosis | Medical Condition | Treatment including Surgeries | Complications including Anesthetic |
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**MEDICATION HISTORY:**

| Medication | Dose | Frequency | Reason for taking and duration |
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| **Allergies | Describe in detail the reaction |
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| 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** |
|---|---|---|---|
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**OTHER INFORMATION:**

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

| 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 couldn't seem to experience any positive feeling at all | **0** | **1** | **2** | **3** |
| **4** | I experienced breathing difficulty (eg 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 down-hearted 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 wasn't 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** |