**Demographics**

|  |  |
| --- | --- |
| Name |  |
| Date of birth |  |
| Phone number |  |
| Email |  |
| Address |  |

What is the main reason for your consultation?

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**Medical history**

Do you have any major long term medical issues?

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In particular, have you been diagnosed with any of the following:

* High blood pressure
* High cholesterol
* Blood clot in leg or lung
* Breast cancer or breast lesion requiring biopsy
* Ovarian cancer
* Porphyria
* Liver disease
* Osteoporosis or osteopenia or a bone fracture
* Brain Haemorrhage (bleed)

Do you take any medications or supplements?

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Do you have any drug allergies?

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Do you smoke? If so, how many cigarettes do you smoke per day? If no, are you an ex-smoker?

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Do you drink alcohol? If yes, how many alcoholic drinks do you consume in an average week?

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Do you exercise regularly?

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What is your height and weight?

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**Gynaecological history**

At what age did you start having periods?

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Have you ever been pregnant? If so, how many pregnancies and deliveries have you had? Did you have any complications in pregnancy such as miscarriage, obstetric cholestasis, high blood pressure or diabetes?

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Have you any gynaecological diagnoses? Have you undergone any gynaecological procedures?

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Do you suffer from urinary incontinence or frequent urinary tract infections? Do you find sexual intercourse to be painful? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are your smears up to date? Have you ever had an abnormal smear?

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Are you still having periods? If so, are they regular or irregular? Are your periods heavier or lighter than they were previously? Have you noticed any bleeding between your periods? If you are no longer having periods, when did they stop? Have you had bleeding after sexual intercourse?

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Are you using contraception? If so, what type?

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If you are over 50, are you registered with Breast Check?

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Do you have a family history of:

Premature Ovarian Failure

Breast cancer

Ovarian cancer

Blood clots in the legs or lungs

Osteoporosis

Cardiovascular disease

Dementia

Bowel cancer

Type 2 Diabetes

**Declaration**

I understand that my medical data will be retained and stored in compliance with GDPR.

I consent to contact by phone, text or email if deemed necessary.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_