Vitality Clinic
MENOPAUSE & WELLNESS

Dr. Cassie McVeigh
MB BCh BAO MICGP
Member of the British Menopause Society

2 JFK Parade, Sligo, F91 W9YY
0830256732
vitalityclinic.ie
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Demographics

Name	
Date of birth	
Phone number	
Email	
Address	

What is the main reason for your consultation?

_____

_____

_____

_____

_____

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?

_____

_____

_____

Do you have any drug allergies?

_____

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

_____

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

_____

Do you exercise regularly?

_____

What is your height and weight?

_____

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Gynaecological history

At what age did you start having periods?

_____

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?

_____

_____

_____

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

_____

_____

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

_____

_____

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

_____

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?

_____

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

_____

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 _____