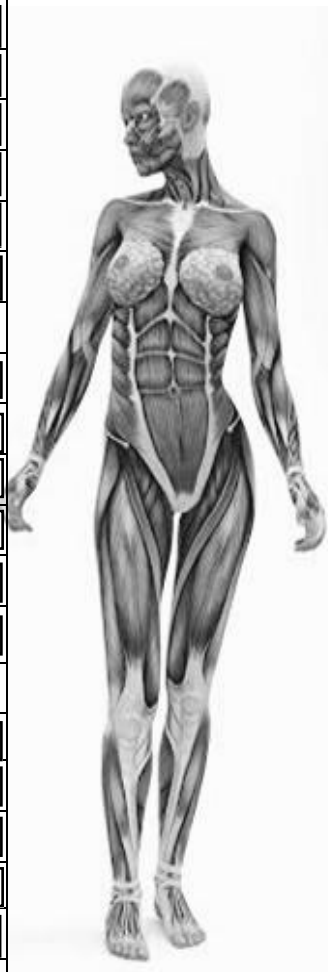
FEMALE PATIENT HEALTH CHECK

TODAY'S DATE: _____

FULL NAME: _____ | DATE OF BIRTH: _____ | AGE: _____

Please mark 'X' where necessary for the following symptoms:	YES	NO
NERVOUS SYSTEM:		
Hearing loss	☐	☐
Vision Change	☐	☐
Headache	☐	☐
Fits/Faints	☐	☐
Limb Weakness	☐	☐
Limb Numbness	☐	☐
Speech Change	☐	☐
Incoordination	☐	☐
CARDIOVASCULAR SYSTEM:		
Chest pain	☐	☐
Shortness of breath	☐	☐
Ankle swelling	☐	☐
Palpitations	☐	☐
Calf pain when walking	☐	☐
Difficulty breathing at night or laying down	☐	☐
GASTRIC SYMPTOMS:		
Indigestion	☐	☐
Difficulty swallowing	☐	☐
Vomiting	☐	☐
Blood in vomit	☐	☐
Weight loss	☐	☐
BOWEL SYMPTOMS:		
Change bowel habit	☐	☐
Loss of appetite	☐	☐
Abdominal pain	☐	☐
Blood from rectum or in bowel motions	☐	☐



Please mark 'X' where necessary for the following symptoms:	YES	NO
RESPIRATORY SYMPTOMS:		
Cough	☐	☐
Phlegm	☐	☐
Coughing up blood	☐	☐
Wheeze	☐	☐
UROLOGICAL SYMPTOMS:		
Increase urine frequency	☐	☐
Urinating at night	☐	☐
Urge to pass urine often	☐	☐
Incontinence	☐	☐
Concern about sexual health	☐	☐
GYNAECOLOGICAL & BREAST SYMPTOMS:		
Current contraception	☐	☐
Previous pregnancies	☐	☐
Regular cycle	☐	☐
Unscheduled vaginal bleed	☐	☐
Vaginal irritation/discharge	☐	☐
Recent breast change/lumps	☐	☐
MOOD SYMPTOMS:		
Poor sleep	☐	☐
Lack of enjoyment	☐	☐
Anxiousness	☐	☐
Depressed	☐	☐
Irritability	☐	☐
Poor concentration	☐	☐

Please also complete the following section found on the next page. If you have a problem answering any questions on this form bring this up in consultation with your Doctor today.

FEMALE PATIENT HEALTH CHECK

Last Menstrual Period:			
Date of Last Pap Smear:			
Date of Last Mammogram:			
Significant Medical History:			
Family History of Health Problems:			
Average Alcohol Weekly Intake:			
Please tick your Smoking Status:	☐ Never Smoked	☐ Ex Smoker	☐ Currently Smoke
Allergies/Adverse Reactions to Medication:			
List of Current Medications:			

Please print as a PDF and send as an attachment to:- forms.highpoint@guardianmedical.com.au