

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:			