

# Patient registration

## Gynaecology

Date completed: \_\_\_\_\_

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

### What is your main concern? What would you most like help with?

How long has this been a concern? What would you most like to achieve from your care? (A short description is enough):

### Symptoms now:

Bleeding: ☐ Heavy periods ☐ Irregular periods ☐ Between periods ☐ After sex ☐ After menopause

Pain: ☐ Pelvic pain ☐ Painful periods ☐ Pain with sex ☐ Vulval/vaginal pain

Other symptoms: ☐ Bladder symptoms/incontinence ☐ Bowel symptoms ☐ Pressure/prolapse ☐ Vulval/vaginal symptoms

Other concerns: ☐ Fertility concern ☐ Recurrent pregnancy loss ☐ Menopausal symptoms ☐ Other: \_\_\_\_\_

### Periods, menopause and pregnancy:

First day of your last menstrual period: ☐ Unsure ☐ Not applicable Date: \_\_\_\_\_

Usual cycle: ☐ Regular ☐ Irregular ☐ No periods ☐ Unsure

Menopause: ☐ Not menopausal ☐ Perimenopausal ☐ Postmenopausal Approximate age/date of final period: \_\_\_\_\_

Could you currently be pregnant? ☐ No ☐ Yes ☐ Unsure ☐ Not applicable

Current contraception or hormone therapy: ☐ None ☐ Pill ☐ IUD ☐ Implant ☐ Barrier ☐ MHT/HRT ☐ Other: \_\_\_\_\_

Any tests or treatments already tried for this concern? ☐ No ☐ Yes, brief details: \_\_\_\_\_

### Relevant gynaecological background:

Have you ever been diagnosed with any of the following? ☐ Endometriosis ☐ Adenomyosis ☐ Fibroids ☐ PCOS/PMOS ☐ Ovarian cysts

☐ Pelvic infection/STI ☐ Prolapse ☐ Urinary incontinence ☐ Infertility/recurrent loss ☐ Gynaecological cancer ☐ None of these

Previous gynaecological procedures or surgery: ☐ None ☐ Colposcopy/LLETZ/cone biopsy ☐ Laparoscopy ☐ Hysteroscopy/D&C

☐ Other surgery, brief details/year: \_\_\_\_\_

Cervical screening: ☐ Never ☐ Unsure Last test: \_\_\_\_\_ Result/follow-up: \_\_\_\_\_

Previous pregnancies (if applicable): Pregnancies: \_\_\_\_\_ Births: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Ectopic: \_\_\_\_\_ Terminations: \_\_\_\_\_ ☐ Prefer to discuss

## Health and medicine review:

Major medical conditions: ☐ None ☐ Yes, brief details: \_\_\_\_\_

Previous operations: ☐ None ☐ Yes, brief details: \_\_\_\_\_

Have you had problems with anaesthetics? ☐ No ☐ Yes

Current medicines, hormones and supplements: ☐ None ☐ Yes, list: \_\_\_\_\_

Allergies or medicine reactions: ☐ None known ☐ Yes, list allergy & reaction: \_\_\_\_\_

Height (cm): \_\_\_\_\_ Weight (kg): \_\_\_\_\_

Smoking: ☐ No ☐ Yes ☐ Recently stopped ☐ I would like support to reduce or stop

Vaping: ☐ No ☐ Yes ☐ Recently stopped ☐ I would like support to reduce or stop

Alcohol: ☐ None ☐ Yes ☐ I would like support to reduce or stop ☐ Approximate amount/week: \_\_\_\_\_

Other substance use: In the past 12 months, have you used recreational or non-prescribed substances, or medicines other than as directed?

☐ No ☐ Yes, brief details: \_\_\_\_\_ ☐ Prefer to discuss privately

Mental health, neurodivergence and supports: ☐ No current concerns ☐ Anxiety/depression ☐ ADHD ☐ Autism

☐ Current professional support ☐ Other: \_\_\_\_\_

Anything that would help your care? \_\_\_\_\_

## Relevant family history – Has a blood relative had any of the following?

☐ Breast cancer ☐ Ovarian/fallopian tube cancer ☐ Endometrial cancer ☐ Bowel cancer ☐ Blood clots

☐ BRCA/Lynch syndrome or another inherited condition Relative/age or details: \_\_\_\_\_

Family history: ☐ None known ☐ Unsure Anything else relevant: \_\_\_\_\_

## Supporting your care – Is there anything you would like us to know before the consultation or examination?

For example: communication or accessibility needs, a support person, previous difficult examinations or trauma, or a preference to discuss something privately:



### Urgent symptoms?

This form is **not monitored for urgent concerns**. If you have severe or rapidly worsening pain, very heavy bleeding, feel faint or acutely unwell, **seek urgent medical care** or call 000.