AWARE WOMEN'S HEALTH

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Heavy or Problem Periods Questionnaire

Please complete this form and return it to the rooms prior to, or at the time of your consultation.

NAME AND CONTACT DETAILS

Name:

Date of birth:

Number of pregnancies:

Number of children:

SYMPTOMS

How long have you had trouble with heavy periods?

How many days do your periods last?

How frequent are your periods (days from start of one period to start of next)?

How many days are heavy?

How many times a day do you change pads/tampons?

Do you experience flooding? Y / N

Have you ever been anaemic? Y / N

Are you taking iron tablets? Y / N

Do you have any associated period pain? Y / N

PREVIOUS INVESTIGATIONS AND TREATMENT

What kind of health care provider have you previously seen in relation to this problem?

- ☐ GP
- ☐ Gynaecologist
- ☐ Alternative therapist, please specify:
- ☐ Other, please specify:

Have you had previous investigations for this problem (eg. Ultrasound, D&C)? Y / N

Have you had previous treatment? Y / N

Have you ever been diagnosed with:

- ☐ Fibroids
- ☐ Adenomyosis
- ☐ Endometriosis
- ☐ Pelvic inflammatory disease

When was your last PAP smear?

Was the result normal? Y / N

TREATMENT EXPECTATIONS

What kind of treatment are you interested in:

- ☐ Medical
- ☐ Hormonal
- ☐ Mirena IUCD
- ☐ Surgical
- ☐ Lifestyle