Dr. Honey & Dr. Cochen
Obstetrics and Gynecology

Consult for Painful/Heavy Periods
Patient Questionnaire

Name:________________________________ Date:____________

Please answer the following:

What is your age?______
How many times have you been pregnant?______ . Number of children?____.
What are you doing to prevent pregnancy? (pill, vasectomy etc.)___________.
What was the **first** day of your last period?_________. Are they regular? (Y / N).
How many days from the beginning of one period to the next? 28? 26-35?_____.
How many days does your period last?__________.
Are the periods heavy? (Y / N) Which days?______.
Are the periods painful? (Y / N) Which days?_______.
How long have you had a problem with your periods?_________.
What treatments have you tried?___________________________.
What treatment are you interested in?_____________________.

General health:

List any medical conditions that you have:____
Have you been diagnosed with Sleep Apnea? (Y / N)
List any surgeries that you have had:____
List your medications and dosages:____
List any allergies to medications**:**________________________________Latex Allergy? (Y / N)
Are you a smoker? (Y / N). How Much?_____. Drinks per week______. Cannibis ? (Y / N)
When was your last Pap smear?______. Have you had any abnormal Paps(Y / N)

Family History:

Do you have a family history of breast, ovary, uterine or cervical cancer? (Y / N)
Please list which family member had which of the above cancers.____________________________________

Social History:

Do you have a partner?_____ What do you do for a living?___________________________________

What would you like to review today?____

Thank you for completing this questionnaire!

308-1 Centrepointe Dr.
Ottawa, ON
K2G 6E2
Tel: 613-274-7282 Fax: 613-274-2970