## Female Health Questionnaire

***These questions have been designed to give a clearer picture of your past and present health which will help determine which tests to do. All your answers are confidential and will only be seen by the health assessor.***

The form is designed to be filled in on your computer. Only use the shaded areas which will expand to fit your answers, where needed.

Once completed, save the form as:

 ***Female\_Health\_xxxxxxxxxxx.docx*** (insert your first and last name) and attach to an email addressed to enquiries@pulsescreening.co.uk at least two days before your appointment. The form can be encrypted, if you wish but please send a separate email with the password.

|  |  |  |
| --- | --- | --- |
| **Date:** |  |  |
|  |
| **Name:** |  |  |
|  |  |
| **Address:** |  |  |
|  |  |
| **Email:** |  |  |
|  |  |
| **Tel No:** |  |  |
|  |  |
| **Date of Birth:** |  |  |
|  |
| **Occupation:** |  |  |

**What is/are your main health concern(s)?** *(Your reason(s) for the consultation)*

|  |
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|  |

**Personal Medical History:**

*Please put a* ***Y*** *for* ***Yes*** *and leave blank for* ***No****. If you are unsure, put* ***?*** *in box.*

|  |
| --- |
| **1) Do you, or have you ever suffered from any of the following cardiovascular disorders?** |
| Heart Attack |  | Angina |  | Recurrent Chest Pain |  | Palpitations |  | High Blood Pressure |  |
|  |
| Heart Murmur |  | Irregular Pulse |  | High Cholesterol |  | Valve Disease |  |
| *If yes, please give details, including any treatment, outcome etc.* |
|  |
| **2) Do you, or have you ever suffered from any of the following disorders of the brain?** |
| Stroke |  | Dizziness |  | Epilepsy |  | Convulsions |  |
| *If yes, please give details, including any treatment, outcome etc.* |
|  |
| **3) Do you, or have you ever suffered from any of the following nervous disorders?** |
| Anxiety |  | Depression |  | Stress |  | Anorexia/Bulimia |  |
| *If yes, please give details, including any treatment, outcome etc.* |
|  |
| **4) Do you, or have you ever suffered from any of the following respiratory disorders?** |
| Asthma |  | Chronic Bronchitis |  | Breathlessness |  | Coughing Up Blood |  |
| *If yes, please give details, including any treatment, outcome etc.* |
|  |
| **5) Do you, or have you ever suffered from any of the following urinary system disorders?** |
| Kidney Disease |  | Recurrent Cystitis |  | Stress Incontinence (leaking urine) |  |
| *If yes, please give details, including any treatment, outcome etc.* |
|  |
| **6) Do you, or have you ever suffered from any of the following digestive disorders?** |
| Peptic Ulcer |  | Recurrent Diarrhoea |  | Recurrent Constipation |  | Rectal Bleeding |  |
|  |
| Ulcerative Colitis |  | Crohn’s Disease |  | Coeliac Disease |  | Irritable Bowel Syndrome  |  |
|  |
| Gastric Reflux |  | Belching/Flatulence |  | Abdominal Distension |  | Pain After Meals |  |
| *If yes, please give details, including any treatment, outcome etc.* |
|  |
|  |
| How often do you have a bowel movement? (e.g, x1 a day, x1 every 2 days) |  |
|  |
| **7) Do you, or have you ever suffered from any of the following liver disorders?** |
| Jaundice |  | Hepatitis A, B or C |  | Cirrhosis |  |
| *If yes, please give details, including any treatment, outcome etc.* |
|  |
| **8) Do you, or have you ever suffered from any of the following disorders of the muscles or joints?** |
| Slipped Disc |  | Osteo Arthritis |  | Rheumatoid Arthritis |  | Gout |  |
|  |
| Neck Pain |  | Back Pain |  | Fracture(s) |  | Numbness/Tingling |  |
| *If yes, please give details, including any treatment, outcome etc.* |
|  |
| **9) Do you, or have you ever suffered from any of the following endocrine disorders?** |
| Diabetes Type 1 |  | Diabetes Type 2 |  | Thyroid Disease |  | Other Glandular Disease |  |
| *If yes, please give details, including any treatment, outcome etc.* |
|  |
| **10) Do you, or have you ever suffered any disease or disorder of the following?** |
| Skin |  | Eyes |  | Ears |  | Nose |  | Throat |  | Mouth |  |
| *If yes, please give details, including any treatment, outcome etc.* |
|  |
| **11) Have you ever been diagnosed with any form of the following?** |
| Cancer |  | Tumour |  | Cyst |  | Lump |  |
| *If yes, please give details, including where in the body, any treatment, outcome etc?* |
|  |
| **12) Do you, or have you ever suffered from any of the following blood disorders?** |
| Iron-Deficiency Anaemia |  | Pernicious Anaemia |  | Leukaemia |  | Sickle Cell Disease/Thalassaemia |  |
| *If yes, please give details, including any treatment, outcome etc.* |
|  |
| **13) Do you suffer from any of the following progressive debilitating diseases?** |
| Parkinson’s Disease |  | Multiple Sclerosis |  | Lupus |  | Other |  |
| *If yes, please give details, including any treatment, outcome etc.* |
|  |
| **14) Do you suffer from any of the following debilitating conditions?** |
| Chronic Fatigue Syndrome (M.E) |  | Fibromyalgia |  | Migraine |  |
| *If yes, please give details, including any treatment, outcome etc.* |
|  |
| **15) Have you recently undergone any of the following investigations?**   |
| Xray |  | ECG |  | CT Scan |  | MRI Scan |  | Ultrasound |  | Blood Tests |  | Other |  |
| *If yes, please give details, including any treatment, outcome etc.* |
|  |
| **16) Have you ever undergone a surgical operation?**  |
| *If yes, please give details, including any treatment, outcome etc.* |
|  |
| **17) Have you ever suffered from any serious injury requiring hospital treatment?**   |
| *If yes, please give details, including any treatment, outcome if not mentioned elsewhere on this form.* |
|  |
| **18) Have you ever received treatment from a Complementary/Alternative Health****Practitioner?** |
| *If yes, please give details, including any treatment, outcome etc.* |
|  |

**Do you currently take any medication? If yes, please state the name of the drug(s) you take, dosage and how often.**

|  |  |  |
| --- | --- | --- |
| **Name of Drug** | **Dosage** | **Times a Day** |
|  |  |  |
|  |  |  |
|  |  |  |
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**Do you currently take any dietary supplements? If yes, please state the name of the supplements you take, dosage and how often.**

|  |  |  |
| --- | --- | --- |
| **Name of Supplement** | **Dosage** | **Times a Day** |
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**Do you currently experience any of the following symptoms?** *Please put a* ***Y*** *for* ***Yes*** *and leave blank for* ***No****. If you are unsure, put* ***?*** *in box*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Cravings for: Salt |  | Sugar |  | Starchy Foods |  |
|  |
| Loss of appetite |  | Weight gain |  | Weight loss |  |
|  |
| Feel faint if you miss a meal |  | Feel irritable if you miss a meal |  |
|  |
| Feel thirsty more often |  | Have dry skin |  |  |
|  |
| Difficulty falling asleep at night |  | Wake often |  | Wake early |  |
|  |
| Low energy in the afternoon |  | Burst of energy late evening |  | Exhausted after exercise/exertion |  |
|  |
| Sensitive to cold |  | Feel light-headed if you get up from a chair or bed too quickly |  |
|  |
| Frequent colds/flu/infections |  | Cold hands and feet |  | Poor circulation |  |
|  |
| Ankles swell on sitting/standing |  | Ankles swell in hot weather |  |  |
|  |
|  Headaches  |  | No. a month |  | Brain Fog |  | Poor Memory |  |
|  |
|  |
| Do you suffer from any allergies? |  |  |
|  |
| If yes, what are you allergic to? |  |
|  |
| Has your allergy been confirmed by a specialist or test? |  |  |
|  |  |
| Do you suffer from any food intolerances? |  |  |
|  |
| If yes, what are you intolerant to? |  |
|  |
| Has your intolerance been confirmed by a specialist or test? |  |  |

**Hormonal Health:**

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| --- |
| ***Pre-Menopause*** *(only answer the following if you have* ***not*** *gone through the menopause, yet)* |
|  |
| Are your periods regular? |  | Approx. no. of days of cycle? |  |
|  |
| Do you suffer from Pre-Menstrual Tension? |  |  |
|  |
| Do you use a medicated form of contraception? (e.g. pill, injection, coil) |  |  |
|  |
| If yes, which type(s)? |  |
|  |
| How long have you been using this form of contraception? |  |
|  |
| Have you ever had any form of fertility treatment? |  |  |
|  |
| If yes, what type of treatment were you given? *(e.g. IVF, egg stimulant, surgery)* |  |
|  |
| **-------------------------------------------------------------------------------------------------------------------------------------------------------------** |
|  |
| ***Post-Menopause*** *(only answer the following if you have gone through the menopause)* |
|  |
| Do you experience hot flushes? |  | If yes, how long have you experienced them? |  |
|  |
| Approximately how many hot flushes do you have during the day? |  |  |
|  |
| Approximately how many hot flushes do you have during the night? |  |  |
|  |
| Do you take HRT? |  | If so, what is your medication? |  |
|  |
| How long have you been on HRT? |  |  |
|  |
| **Breast Health** |
| Do you routinely examine your breasts for lumps? |  |  |
|  |
| Have you ever noticed a breast lump? |  | If yes, did you seek medical advice? |  |
|  |
| What was the outcome? |  |
|  |
| How many hours a day do you wear a bra? More than 12 hours |  | Less than 12 hours |  |
|  |
| Do you use an anti-perspirant? |  |  |
|  |
| When did you have your last cervical smear test? |  |
|  |
| Have you ever had an abnormal cervical smear? |  | If so, when? |  |
|  |
| **Pregnancy History -** *please fill in this section if you have been pregnant in the past* |
|  |
| How many live births have you had? |  | Have you had any miscarriages? |  |
|  |
| If yes, how many? |  | How many weeks pregnant were you? |  |
|  |

**Dental Health:**

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| --- | --- | --- |
| Do you visit a dentist regularly? |  |  |
|  |
| Do you have mercury (silver) fillings? |  |  |
|  |
| Do you suffer from mouth ulcers? |  | If yes, how often? Occasionally |  | Regularly |  |
|  |
| Do you have any root canals/fillings? |  |  |
|  |

**Lifestyle:**

|  |  |  |
| --- | --- | --- |
| Do you do any form of exercise/activity? |  |  |
|  |
| If yes, what do you do? |  |
|  |
| How often do you do this? |  |
|  |
| Do you have a sedentary job/lifestyle? |  |  |
|  |
| Do you smoke? |  | If yes, what do you smoke: | Cigarettes |  | Cigars |  | Pipe |  | Other |  |
|  |
| How many a day? |  |  |
|  |
| If you do not smoke, have you ever smoked? |  | When did you stop? |  |
|  |
| What is your average weekly consumption of alcohol in units?*(one unit = ½ pt beer, small glass of wine, pub measure of spirits)* |  |
|  |
| If less than 1 unit, how many in a month? |  |  |
|  |
| Do you use supermarket or main brands of toiletries (shampoo, conditioner, toothpaste etc)? |  |  |
|  |
| Do you use supermarket or main brands of household cleaning products? |  |  |
|  |
| Do you use air fresheners (any type)? |  |  |
|  |
| Do you use a mobile phone? *Regularly* (several times a day) |  | *Occasionally* (less than 3 times a week) |  |
|  |
| What percentage of your mobile phone use is for making calls? (excluding texting and other activities)  |  | % |
|  |
| Where do you keep your mobile phone when it is switched on? (e.g. pocket, bag etc.) |  |
|  |
| Do you keep your mobile phone switched on beside or near your bed at night? |  |  |
|  |
| Do you use a cordless (DECT) phone at home or work? |  |  |
|  |
| If yes, where is the base station situated? |  |
|  |
| Do you have a WiFi Router at home or work? Work |  | Home |  |  |
|  |
| If you have WiFi at home, do you turn the WiFi connection off at night? |  |  |
|  |
| Are you currently suffering from any emotional stress? *e.g family problems, financial worries etc.* |  |
|  |

**Diet:**

|  |  |  |
| --- | --- | --- |
| Do you eat at least 5 portions of fruit and vegetables a day? |  |  |
|  |
| Do you eat meat? |  | Do you eat fish? |  | Are you a Vegetarian? |  | Are you a Vegan? |  |
|  |
| Do you include roughage (high fibre foods) in your diet? |  |  |
|  |
| Do you eat convenience/processed food and takeaways? |  |  If yes, how often? |
|  |
| <1 a week |  | 1-2 x a week |  | 3-6 x a week |  | Every day |  |
|  |
| Do you eat organic produce? Regularly |  | Occasionally |  | Rarely |  |
|  |
| Do you usually add sugar to beverages or breakfast cereals? |  |  |
|  |
| Do you use artificial sweeteners? |  | If so, which brand? |  |
|  |
| Do you consume dairy products? |  | Do you eat margarine? |  |  |
|  |
| Do you drink tap water? |  | Do you use a water filter?  |  | Do you drink bottled water? |  |
|  |
| Do you drink caffeinated tea or coffee? |  | Do you drink fizzy drinks? |  | Do you drink “diet” drinks? |  |
|  |
| Do you use a Microwave oven to cook, defrost or reheat food/drink? |  |  |
|  |
| Do you regularly eat your main meal after 7pm? |  |  |

**Thank you for completing the form**