

Heavy Periods Questionnaire

Please complete this form and email, fax or post it to the rooms prior to your consultation.

PATIENT PROFILE

Name: DOB:

Periods Duration..... First day of last period

Length of period (days) Length of cycle (days)

How often do you change pads/tampons?

PAIN – with period	Yes	No
before period	<input type="checkbox"/>	<input type="checkbox"/>
after period	<input type="checkbox"/>	<input type="checkbox"/>
amount	
(see chart enclosed)		

Number of pregnancies Number of children:

SURGERY (tick box)	Yes	No
D & C	<input type="checkbox"/>	<input type="checkbox"/>
Hysteroscopy	<input type="checkbox"/>	<input type="checkbox"/>
Other surgery	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL THERAPY (tick box)	Yes	No
Norethisterone (Primolut N)	<input type="checkbox"/>	<input type="checkbox"/>
Provera	<input type="checkbox"/>	<input type="checkbox"/>
Naprosyn, Nurofen, Ponstan or similar e.g. Naprogesic	<input type="checkbox"/>	<input type="checkbox"/>
Danazol	<input type="checkbox"/>	<input type="checkbox"/>
Cyklokapron	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

Any other relevant information:

.....
.....
.....
.....