Logo, company name

Description automatically generatedNAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

VISIT: 1 2 3 4 5

Please mark a box with a (✓) or a cross (🗶) to show how much you are troubled at the moment by any of these symptoms.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Symptoms | Not at all | A little | Quite a bit | A lot / very much |
| 1. Heart beating quickly or strongly |  |  |  |  |
| 2. Feeling tense or nervous |  |  |  |  |
| 3. Difficulty in sleeping |  |  |  |  |
| 4. Excitable |  |  |  |  |
| 5. Memory problems |  |  |  |  |
| 6. Attacks of panic or anxiety |  |  |  |  |
| 7. Difficulty in concentrating |  |  |  |  |
| 8. Feeling tired or lack of energy |  |  |  |  |
| 9. Loss of interest in most things |  |  |  |  |
| 10. Feeling unhappy or depressed |  |  |  |  |
| 11. Crying spells |  |  |  |  |
| 12. Irritability |  |  |  |  |
| 13. Feeling dizzy or faint |  |  |  |  |
| 14. Pressure or tightness in head or body |  |  |  |  |
| 15. Tinnitus (ringing or buzzing in ears) |  |  |  |  |
| 16. Headaches |  |  |  |  |
| 17. Muscle or joint pains |  |  |  |  |
| 18. Pins and needles in any part of the body |  |  |  |  |
| 19. Breathing difficulties |  |  |  |  |
| 20. Hot flushes |  |  |  |  |
| 21. Sweating at night |  |  |  |  |
| 22. Loss of interest in sex/loss of libido |  |  |  |  |
| 23. Vaginal dryness |  |  |  |  |
| 24. Urinary symptoms |  |  |  |  |

Now complete the second page of our questionnaire which also includes how to return the completed form to us

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|  |  |
| --- | --- |
| **Medical History** | |
| Last menstrual period |  |
| Your menstrual cycle (duration of bleeds, frequency between bleeds, any changes)? |  |
| Do you experience any bleeding after sex? |  |
| Have you had any gynaecological surgery (at any time)? |  |
| What current contraception are you on? (if none, please state none) |  |
| Smoking status (as much detail as possible eg how many cigarettes a day or grams of tobacco if roll ups) |  |
| Migraine history |  |
| Any family history of breast or ovarian cancer (please state relative and age of relative) |  |
| Do you use any complimentary medicines (eg St John’s wort) |  |
| Your height |  |
| Your weight |  |
| Blood pressure reading |  |
| Please let us know your availability (days/times of the week) |  |

You send this form back to us either by attaching it to an askmyGP request or can email it to us at [bnssg.168enquiries@nhs.net](mailto:bnssg.168enquiries@nhs.net)