Women's Health Road

6 Hilmer St, Frenchs Forest, NSW 2086

Heavy Menstrual Bleeding (HMB) Patient Questionnaire

First Name _____ Surname _____

Preferred Name: _____ DOB: ____ / ____ / _____ Email: _____

Please outline your main health related concern(s):

_____

PAST MEDICAL HISTORY:

Please **check** any past or current medical conditions that apply to you:

☐ Arthritis	☐ Eating Disorder	☐ Insomnia	☐ Endometriosis
☐ Asthma / COPD	☐ Epilepsy	☐ Kidney Disease	☐ Adenomyosis
☐ Chronic Fatigue	☐ Fibromyalgia	☐ Malnutrition	☐ PCOS
☐ Blood & Clotting Disorders	☐ Diabetes	☐ Osteoporosis	☐ Uterine Fibroids
☐ Crohn's / Colitis	☐ Low Blood Pressure	☐ Stroke	☐ Uterine/Cervical Polyps
☐ Depression	☐ High Blood Pressure	☐ Varicose Veins	☐ Interstitial Cystitis
☐ Anxiety	☐ High Cholesterol	☐ Anaemia/Iron Deficiency	☐ Pelvic Organ Prolapse
☐ ADHD	☐ Migraines		

☐ Childhood Disease: _____

☐ Cardiovascular Disease: _____

☐ Cancer: _____

☐ Other: _____

MENSTRUAL HISTORY: (FIGO AUB PARAMETERS, SAMANTA, VAS, PIPPA)

Age of first menstrual period: _____ **Date your last period began:** _____ **Duration of menstrual period:** _____ (days)

Regularity of period length: ☐ Regular variation ☐ Irregular **Flow Volume:** ☐ Heavy ☐ Normal ☐ Light

Please assess the intensity of your menstrual bleeding, generally (indicate on the scale below):

0 1 2 3 4 5 6 7 8 9 10

No bleeding at all — The heaviest possible menstrual bleeding I have ever had

No. days between periods: ☐Absent (no periods/bleeding) ☐Frequent (< 24 days) ☐Normal (24 - 38 days) ☐Infrequent (>38 days)

Predictability (regularity) **of cycle length:** ☐ Absent (no periods/bleeding ☐ Predictable (regular, varies by 2-7 days in length)
☐ Unpredictable (irregular, varies by > 10 days in length)

Do you experience any Intermenstrual Bleeding (IMB) (bleeding in between periods):

☐ None ☐Random ☐ Cyclic/Predictable (☐ Early Cycle / ☐ Mid Cycle / ☐ Late cycle)

To what extent does your period impact your daily activities (please indicate on the scale below):

0 1 2 3 4 5 6 7 8 9 10

It does not interfere with my daily activities at all — It completely interferes with my daily activities

During heavier bleeding days do you:

Have to use double protection or get up to change your sanitary protection during the night? ☐ Yes ☐ No

Worry about staining the seat of your chair, sofa, etc? ☐ Yes ☐ No

Avoid certain activities, travel, or leisure plans, because you need to change your tampon or pad frequently? ☐ Yes ☐ No

Period Pain

Do you have period pain? ☐ Yes ☐ No ☐ Occasionally Pain Score (0-10) _____

If so, how old were you when your periods became painful? _____

How many days each month do you have period pain for? _____

Where do you feel your period pain?

☐ Low abdomen at the front ☐ Lower back ☐ Left side lower abdomen

☐ Right side lower abdomen ☐ Front at the legs ☐ Back of the legs

☐ Foot ☐ Anal area ☐ Other _____

Do period **pain medications** (ibuprofen, Ponstan, Naprogesic etc.) help your period pain?

☐ Yes ☐ a little ☐ not at all ☐ I have ever tried these medications

SEXUAL AND REPRODUCTIVE HISTORY:

Are you currently sexually active? ☐ Yes ☐ No **Are you currently trying to get pregnant?** ☐ Yes ☐ No ☐ Want in future

Do you experience any bleeding after sexual intercourse? ☐ Yes ☐ No

Do you experience any excessive pain during sexual intercourse? ☐ Yes ☐ No

If yes, how would you describe this pain on a scale from 1 – 10? _____

What contraception, if any, are you currently using? For how long? _____

For any hormonal contraception, what impact has this had on your period/cycle? (flow volume, duration, frequency etc.):

_____

What contraception options, if any, have you used in the past? _____

For any previous hormonal contraception, what impact did they have on your period/cycle?

_____

Do you have any current or a previous history of sexually transmitted diseases? ☐ Yes ☐ No

If YES, please provide detail (date, type, treatment): _____

Do you have any other sexual dysfunctions/issues related to sex? _____

Please let us know of any previous pregnancy history including abortions & miscarriages (*if comfortable*):

Birthplace & Date	Gestation	Type of Birth / Model of Care e.g. Midwife, Public/Private OB, Vaginal or C/S	Birth Weight	Name/Sex of Child *(if applicable)*

Cervical Screening Test (CST):

When was your most recent CST (Pap Smear) and what was the result?

Date: _____ Result: _____

Any past abnormal CST(s)? Please provide details: _____

If possible, please provide a copy of your most recent screening test(s) results or bring a copy of these results with you on the day of your appointment.

ASSOCIATED OR SYSTEMIC SYMPTOMS:

Do you experience any **pelvic pain?** ☐ Yes ☐ No If YES, indicate on the scale of 1 – 10 below how you would describe this pain:

0	1	2	3	4	5	6	7	8	9	10
Little to no pain					Moderate Pain					Severe Pain

Have you noticed any abnormal **vaginal discharge?** ☐ Yes ☐ No

If YES, please provide detail: _____

Do you currently have any **urinary and/or bowel related concerns?** ☐ Yes ☐ No

If YES, please provide detail (i.e. motion of passing/incontinence issues etc.)

_____

_____

What is your current **weight**? _____ kg What is your **height**? _____ cm

Have you noticed any significant weight loss or gain? ☐ Yes ☐ No Details: _____

Have you had any **blood tests** done in the past 12 months? ☐ Yes ☐ No Date of most recent test: _____

Pathology Provider (e.g. Douglas Hanly Moir, Laverty, Aus Clinical Labs etc.): _____

Any clinically significant bloods results & outcomes? _____

Have you had any **medical imaging** (i.e. Ultrasound, MRI – of pelvis/abdomen) done in the past 12 months? ☐ Yes ☐ No

Type of Imaging	Date	Imaging Provider & Location	Clinical Reason	Results / Findings

CURRENT MEDICATIONS:

Medication	Dose	Frequency	Reason for Medication	Duration you have been taking this medication for

FAMILY HISTORY:

Blood and Clotting Disorders

- ☐ Von Willebrand disease
- ☐ Haemophilia
- ☐ Thrombophilia (e.g. Factor V Leiden, Protein C/S deficiency)
- ☐ Easy bruising or excessive bleeding
- ☐ History of blood clots (DVT, stroke before age 50)

Endocrine and Hormonal Conditions

- ☐ Thyroid Disease
- ☐ PCOS
- ☐ Diabetes (Type 1 or Type 2)
- ☐ Early menopause / premature ovarian insufficiency
- ☐ Adrenal disorders

Cancer / Malignancy

- ☐ Breast Cancer
- ☐ Ovarian cancer
- ☐ Uterine (endometrial cancer)
- ☐ Cervical cancer
- ☐ Colon cancer (<50 yrs or related to Lynch Syndrome)
- ☐ Other hereditary cancers (e.g. BRCA1/2, Lynch Syndrome)

Other relevant conditions

- ☐ Endometriosis or adenomyosis
- ☐ Fibroids
- ☐ Osteoporosis or early bone loss
- ☐ Cardiovascular disease (☐ <55 yrs)
- ☐ Autoimmune conditions
- ☐ Genetic syndromes (e.g. Turner syndrome, Kallmann syndrome)

If you answered 'Yes' to any of the above, please provide detail (i.e. date & age at diagnosis, outcome of diagnosis, type of cancer etc.)

_____

_____

SOCIAL HISTORY

Do you currently have a partner(s)? ☐ Yes ☐ No

If you are comfortable to share, what is your partner/s' name and sex/gender/age? _____

Are you currently **working?** ☐ Yes ☐ No

Employment Type (PT, FT, Casual): _____ Occupation: _____

Are you currently **studying?** ☐ Yes ☐ No Institution: _____ Level & Area of study: _____

Lifestyle

Do you currently **smoke?** ☐ Yes ☐ No ☐ In Past ☐ Vape Do you take any **recreational drugs?** ☐ Yes ☐ No

How often do you drink **Alcohol?**

☐ Never ☐ < Monthly ☐ 1 – 2 days per month ☐ 1-2 days a week ☐ 3-4 days a week ☐ 5-6 days a week ☐ Everyday

On Each occasion, how much do you normally drink? ☐ 1 – 3 ☐ 3-5 ☐ 5-7 ☐ 7+

1 drink = 1 can of beer, 1 glass of wine, or 1 shot of spirits

How many hours of **physical activity** do you do on an average week? _____hrs. Frequency: _____ Intensity: _____

SURGICAL HISTORY

Year	**Place of Surgery**	**Details** (Surgeon, Type of Procedure, any complications or issues?, findings)

MENOPAUSE (if applicable)

On the Modified Greene Scale below, judge the severity of your symptoms and record the score.

Symptom	0 None	1 Mild	2 Moderate	3 Severe
Hot flushes				
Lightheaded feelings				
Headaches				
Irritability				
Depression				
Unloved feelings				
Anxiety				
Mood changes				
Sleeplessness				
Unusual tiredness				
Backache				
Joint pains				
Muscle pains				
New facial hair				
Dry skin				
Crawling feelings under the skin				
Less sexual feelings				
Dry vagina				
Uncomfortable intercourse				
Urinary frequency changes				
TOTAL:				

OTHER NOTES

Please use the space below to let us know of anything else we can do or need to note to best support your health journey at WHR: