

## GYNECOLOGICAL DISORDERS QUESTIONNAIRE

### **Abnormal Cervical Smear Test (PAP Test)**

1. Have you ever had an abnormal cervical smear (PAP) test or needed treatment or follow-up tests following a smear test? If yes, please provide dates of treatment and last follow-up consultation. \_\_\_\_\_  
\_\_\_\_\_
2. Have all follow-up PAP tests been normal? \_\_\_\_\_
3. Please give the date of your last normal PAP test \_\_\_\_\_

### **Other Gynecological Problems**

4. What was the precise diagnosis of your condition, or what surgical procedure or investigation did you undergo? \_\_\_\_\_  
\_\_\_\_\_
5. Please give the approximate date when you last experienced problems or symptoms \_\_\_\_\_
6. How often, within the last 12 months, have you had problems or attacks with this condition? \_\_\_\_\_
7. Have you had an operation for this condition? Please provide date of last operation. \_\_\_\_\_
8. Have there been any problems or complications following surgery? \_\_\_\_\_
9. Are you awaiting an operation for this condition? \_\_\_\_\_
10. Have you taken prescribed medication for this condition within the last 6 months? Please provide name, dosage and how often taken. \_\_\_\_\_  
\_\_\_\_\_
11. Please give date of your last consultation or treatment for this condition. \_\_\_\_\_
12. Were any problems or complications identified, requiring treatment or further consultation? \_\_\_\_\_
13. Have you lost any time off work in the last 2 years because of this condition? Please give dates and duration of absences. \_\_\_\_\_  
\_\_\_\_\_

Client's Signature:

Date:

