CONSULTATION CHECKLIST

Date:	
Age	
Background and Occupation:	
Aims of the consultation:	
SYMPTOMS	
Physical	
☐ Irregular periods	
☐ Bloating/Gas	
☐ Fluid retention	
☐ Cramping	
☐ Hot flushes – how many and how long do they last?	
☐ Night sweats	
☐ Breast tenderness	
☐ Difficulty falling asleep	
☐ Difficulty staying asleep	
☐ Number of times waking	
☐ Change in bladder function (including incontinence)	
☐ Weight gain or loss	
☐ Increase in belly fat	
☐ Loss of muscle tone	
☐ Dry skin	
☐ Hair loss	
☐ Dry hair	
☐ Dry/Oily skin	
☐ Loss of energy	
Energy score	
Time of low energy	
☐ Palpitations	
☐ Headaches	
☐ Joint pain	
☐ Joint swelling	
☐ Hot/Cold feet or hands	

☐ Diarrhoea/constipation	
☐ General itchiness/formication	
Cognitive	
☐ Memory issues	
☐ Concentration issues	
☐ Difficulty word finding	
Emotional	
☐ Anxiety	
☐ Mood swings	
☐ Anger/Irritability	
☐ Panic attacks	
☐ Depression	
☐ Inability to cope	
☐ Motivation	
Sexual symptoms	
☐ Vaginal dryness	
☐ Low libido	
☐ Reduced sensitivity	
☐ Pain or bleeding during intercourse	
☐ Difficulty reaching orgasm	
PAST GYNAECOLOGICAL HISTORY	
Menarche	
LMP	
IMB or Bleeding 1 year post-menopause	
Contraception	
Pregnancy	
How did you feel in pregnancy?	
Fertility issues	
Operations/Procedures	
Cervical Smear (Date and Result)	
Pelvic Ultrasound Screening (Date and Result)	

Mammogram (Date and Result)	
Other tests/screening	

PAST MEDICAL HISTORY

Any relevant information (e.g. cancer, thrombosis, etc.)

FAMILY MEDICAL HISTORY

Any relevant information (e.g. cancer, thrombosis ,etc.)

MEDICATION HISTORY

Type of Medication	
Vitamins/Supplements	

DIET

Breakfast	
AM snacks	
Lunch	
PM snacks	
Dinner	
Evening snacks	
Caffeine	
Water	

LIFESTYLE

☐ Allergies	
☐ Smoker (if yes, how many per day?)	
☐ Alcohol (if yes, how many units per week?)	

☐ Exercise (If yes, what type and how many hours per week?)	
EXAMINATION	
BP	
Height	
Weight	
BMI	
TREATMENT PLAN	
Blood tests or any other investigations required?	