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| **Mr Kevin F Gangar FRCS MRCOG**Consultant Gynaecologist |

VERY IMPORTANT - Please complete this form, bring it with you when you attend for your appointment and hand it to Mr Gangar or return this document via email: kevin@surreygynaecology.com or fax to 01932 830 873

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |   | First Name |   |
| Address |  |
|  |  |
|  |  | Postcode |   |
| Phone | Home |   |
|  | Mobile |   |
|  | Work |   |
| Email |  |

|  |  |  |
| --- | --- | --- |
| Which GP Practice are you registered with? | Address |   |
|  |
|   | Postcode  |   |

|  |  |  |  |
| --- | --- | --- | --- |
| Age |  | Date of Birth |  |
| Occupation |  |  Marital Status  |  |
| Height |  |  Weight  |  |
| Next of kin |  | Phone |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Have you had a hysterectomy? | Yes / No  | If yes, which year? |  |

|  |  |
| --- | --- |
| When was your last period? |  |
|  | Month and year if possible |

# If you are still having periods

|  |  |
| --- | --- |
| How long do your periods last? |  |
| How often do you get a period? |  |
| Do you have any bleeding between periods? |  |
| Do you have any bleeding after intercourse? |  |

|  |  |
| --- | --- |
| Have you had any gynaecological problems in the past? |  |

|  |  |
| --- | --- |
| Do you take any tablets or medicines on a regular basis? If yes, what? |  |
| Do you suffer from anaemia? |  |

|  |  |
| --- | --- |
| Are you allergic to any medicines such as antibiotics? |  |
| Do you suffer from any bladder problems e.g. leakage, incontinence etc on coughing, sneezing (give details) |  |

|  |  |
| --- | --- |
| Do you smoke? If yes, how many per day? |  |
| Do you drink? If yes, how many per week? |  |
| What contraception do you use? |  |
| Number of children and their ages? |  |
| Have you had any pregnancies? |  |

|  |  |
| --- | --- |
| Date of your last cervical smear (taken from the neck of the womb) |  |

|  |  |
| --- | --- |
| Date of last mammogram (if applicable) |  |
| Have you had any breast lumps in the past? |  |
| Is there any history of breast or ovarian cancer in the family? |  |
| Have you had any operations? |  |
| Are there any serious diseases, which run in your family? |  |

PLEASE DESCRIBE YOUR SYMPTOMS ON ANOTHER PAGE, OR ADD ANY FURTHER INFORMATION YOU FEEL IS RELEVANT.

Do you have Medical Insurance? If yes, please supply name and membership details

# Information/Communication Consent Form

From time to time we may need to contact you with regards your appointments. At no time would our messages contain any sensitive information nor would we speak to anyone other than yourself. If you are happy for us to contact you by phone, please complete the following.

|  |  |
| --- | --- |
| Name |  |

|  |  |
| --- | --- |
| Home number |  |

|  |  |
| --- | --- |
| Mobile number |  |

I agree to receive text messages regarding my appointments.

 I am happy to have messages left on my answerphone.

 I am happy to receive clinical letters and other correspondence on the above email address.

|  |  |
| --- | --- |
| Signed |  |

|  |  |
| --- | --- |
| Date |  |

Please return this document via email: kevin@surreygynaecology.com or fax 01932 830 873