

Dr Leneque X Lindeque Inc.

Obstetrician and Gynaecologist

PR No: 0160000511226



PATIENT QUESTIONNAIRE

Name: _____ Date of Birth: _____

Date: _____ How old are you? _____

What concern(s) are you presenting to Dr Lindeque? _____

Please provide as much detail as possible about the concern: _____

1. How long have you been aware of the concern? _____

2. Do you have an idea of the cause? _____

3. Have you received any treatment for this concern? _____

4. Other information? _____

5. How old were you when you had your first menstrual period? _____

6. What was the date of your last normal period? _____

7. Describe your normal period? Is the bleeding heavy? Do you have pain? etc _____

8. Have you ever used contraception? Please give details: _____

9. What was the date of your last pap smear? _____ Was it normal? _____

10. How many times have you been pregnant? _____

11. What dates were your children born? _____

12. Did you deliver normally or with a caesarean section? _____

13. Are you sexually active? _____ Are there any problems? _____

14. Do you have any symptoms of menopause? E.g. hot flashes? _____

15. Do you have any concerns with your bladder or bowels? E.g. leaking of urine or constipation? _____

16. If you are older than 40: when last did you have a Mammogram? _____

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17. If you are older than 50: when last did you have a Bone Mass Density Scan? _____

General Medical History:

Do you have any medical conditions? E.g. high blood pressure, diabetes? _____

Please list all operations that you have had: _____

Are you on any medication? _____

Are you allergic to anything? _____

Do you smoke? _____ Do you consume alcohol? _____

What is your occupation? _____

Is there anybody in the family with breast cancer, any other form of cancer, blood clots, high blood pressure, diabetes? _____

Where did you hear about Dr Lindeque's Practice _____