



**LIFESTYLE ISSUES**

**Smoking**       non smoker                       < 10/day                       10-19/day                       20-29/day  
 > 30/day                       occasional/social smoker ..... per week?

**Alcohol**       no alcohol                       < 10/wk                       10-19/wk                       20-29/wk  
 30-39/wk                       >40/wk  
(one unit = ½ pint of beer / small glass of wine / one measure of spirits)

**Exercise**       no exercise                       one session/wk                       2-4 sessions/wk                       >5 sessions/wk

**Are you taking any medication either prescribed or over the counter (including oral contraceptive pill)?**  
 Yes                                       No

If "yes" please specify.....

**Do you have any drug or other allergies?**  
 Yes                                       No

If "yes" please specify.....

**Have you had any medical tests or investigations within the past 3 years?**  
 Yes                                       No

If "yes" please specify.....

**Have you had any operations?**  
 Yes                                       No

**Please give the approximate date of your last cervical smear test.....**

**Have you had any abnormal cervical smear tests?**                       Yes                       No

If "yes" please specify .....

**Have you had any abnormal pregnancies or complications of pregnancy?**     Yes                       No

If "yes" please specify.....

Please indicate whether you would like a chaperone to be present during the examination?      Yes                       No

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.  
WE LOOK FORWARD TO SEEING YOU FOR YOUR HEALTH ASSESSMENT.