

# PREPARING FOR YOUR CONSULTATION

Fact Sheet

To make the most of your consultation with the doctor, take a little time to prepare by using this guide to organise your medical history so that your doctor has more time to focus on your needs.

Please fill in your personal medical, surgical and family history below.

Age: \_\_\_\_\_ years

Do you take medication every day?  YES  NO

If yes, which ones? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

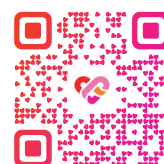
## YOUR GYNAECOLOGICAL AND OBSTETRIC HISTORY

- Age of first menstrual period \_\_\_\_\_
- Number of pregnancies, including miscarriages and abortions \_\_\_\_\_
- Number of children \_\_\_\_\_
- Currently pregnancy \_\_\_\_\_
- Do you use contraception?  YES  NO  
If yes, which one? **Name of contraception** \_\_\_\_\_
- During your pregnancies, did you have a history of high blood pressure? pre-eclampsia? diabetes? growth restriction? foetal death or prematurity (<37 weeks of gestation)?  YES  NO
- Do you have a history of endometriosis and/or polycystic ovary syndrome?  YES  NO



Agir pour  
le Cœur  
des Femmes

Women's Cardiovascular Healthcare Foundation



# PREPARING FOR YOUR CONSULTATION (CONT.)

Fact Sheet

- Are you menopausal?
  - >  YES  NO **Age at onset of menopause** \_\_\_\_\_
  - > Are you undergoing hormonal menopause treatment? .....  YES  NO
- Do you have climacteric symptoms of the menopause? .....  YES  NO  
(hot flushes, irritability, trouble sleeping, fatigue, joint pain, trouble concentrating, vaginal dryness, cystitis, etc.)
- Have you ever had a bone density scan for menopause? .....  YES  NO
  - > **If yes** .....  > 5 years  < 5 years
- Do you have a history of gynaecological surgery such as breast, ovarian or uterine surgery? .....  YES  NO
- Do you have a history of gynaecological cancer? Breast, uterine, ovarian, endometrial .....  YES  NO
  - > **Surgery** .....  YES  NO
  - > **Chemotherapy** .....  YES  NO
  - > **Radiotherapy** .....  YES  NO
  - > **Aromatase inhibitors** .....  YES  NO
- Do you have a first-degree family history of gynaecological cancer (mother, children, sisters)? .....  YES  NO

## YOUR CARDIOVASCULAR HISTORY

- Do you have high blood pressure? .....  YES  NO
- Are you being treated for high blood pressure? If so, which treatment?
  - >  YES  NO **Treatment name** \_\_\_\_\_
- Do you have diabetes? .....  YES  NO
- Are you being treated for diabetes? If yes, which treatment?
  - >  YES  NO **Treatment name** \_\_\_\_\_
- Do you regularly see a diabetologist to monitor your diabetes? .....  YES  NO
- Your last control glycated haemoglobin (A1C) was \_\_\_\_\_
- Do you have a history of sleep apnoea? .....  YES  NO
  - > Do you wear a hearing aid? .....  YES  NO
- Have you ever had depression? .....  YES  NO
  - > Are you being treated with antidepressants and/or anxiolytics? .....  YES  NO
  - > **Treatment names** \_\_\_\_\_

# PREPARING FOR YOUR CONSULTATION (CONT.)



- Have you ever had surgery on your heart and/or coronary arteries, carotid arteries or abdominal aorta? .....  YES  NO
- Do you have a history of heart arrhythmia? .....  YES  NO
- Have you ever had a myocardial infarction, stroke and/or TIA? .....  YES  NO
- Have you ever had heart failure and/or heart valve disease? .....  YES  NO
- Do you have cholesterol plaque in your arteries? .....  YES  NO
- Have you ever had an aortic aneurysm and/or aortic dissection? .....  YES  NO
- Have you ever had phlebitis and/or a pulmonary embolism? .....  YES  NO
- Do you have thyroid problems? .....  YES  NO
- Are you undergoing thyroid treatment? .....  YES  NO

## YOUR FAMILY CARDIOVASCULAR HISTORY

- Do your parents and/or siblings have a history of cardiovascular disease? If yes, what was the age of onset?  
>  YES  NO **Age of onset** .....
- Does obesity run in your family? .....  YES  NO
- Do your parents and/or siblings or children have a history of diabetes? .....  YES  NO

## YOUR MEDICAL OR SURGICAL HISTORY

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## YOUR ALLERGIES

● Medication, food, iodine .....  YES  NO

> If yes, which allergies? \_\_\_\_\_

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\_\_\_\_\_

## YOUR LIFESTYLE

● Do you use tobacco? .....  YES  NO

● Have you quit using tobacco?  YES  NO Year you started using tobacco \_\_\_\_\_

● Number of cigarettes per day \_\_\_\_\_

● Do you regularly use cannabis, other drugs, energy drinks or alcohol? .....  YES  NO

● Do you regularly take medication that can lead to dependence?  
> (sleeping pills, benzodiazepines, painkillers, etc.) .....  YES  NO

● Do you sit for more than 7 hours a day? .....  YES  NO

● How often do you exercise each week? \_\_\_\_\_ hours per week

● Do you add salt to you food and/or eat ready-made meals? .....  YES  NO

## YOUR CARDIOVASCULAR ALARM SYMPTOMS

- Shortness of breath .....  YES  NO
- Palpitations, regular or irregular .....  YES  NO
- Tachycardia, regular or irregular .....  YES  NO
- Lipothymia, Syncope .....  YES  NO
- Anxiety .....  YES  NO
- Pain: chest, back, neck, arms, jaw .....  YES  NO
- Digestive disorders: nausea, upset stomach (burning, heaviness or cramping), suggestive of coronary artery disease .....  YES  NO
- Abdominal pain when eating (digestive arterial disease) .....  YES  NO
- Claudication (leg pain when walking suggestive of arteritis of the lower limbs) .....  YES  NO
- Fatigue during exertion .....  YES  NO
- Morning headaches .....  YES  NO
- Tinnitus, phosphenes .....  YES  NO
- Choking or frequent urination at night .....  YES  NO

## YOUR MEDICAL CHECK-UPS

- How often do you see a GP throughout the year? .....
- Do you get yearly gynaecological exams? .....  YES  NO
- Year of last gynaecological exam .....
- Date of last mammogram (if 50 or older) .....
- Date of last pap smear .....
- Do you regularly see a cardiologist or vascular surgeon? .....  YES  NO
- If you are diabetic, do you have regular eye and kidney check-ups? .....  YES  NO

## PRACTICAL ADVICE FOR YOUR APPOINTMENT

- Organise your **medical binder** (A4 format) with colour-coded dividers to categorise your consultation letters, hospitalisation documents and additional tests by organ (heart and blood vessels, rheumatology, diabetology, endocrinology, pulmonology, etc.).
- In your binder, place **an index card with the names and contact details of your treating doctors** (GP, cardiologist, angiologist, gynaecologist/midwife, endocrinologist, pneumologist, etc.) and the name and contact details of your emergency contact.
- In your binder, place an index card with **all of your current treatments and any known drug intolerances or allergies** (e.g. iodine allergy).
- In your binder, place **all of your current prescriptions** and, before the consultation, ask your doctor to order **a lab test if your last blood test was over a year ago.**
- In your binder, place **all of your recent lab tests that are under than 2 years old.**
- In your binder, place **your electrocardiograms and cardiovascular test reports.**
- **Weigh yourself and measure your abdominal circumference.**
- If you have an at-home blood pressure measurement device, take **your blood pressure over three days** (3 measurements in the morning in a calm, seated position and 3 measurements in the evening before bed in a calm, seated position).
- In your binder, place the **fact sheet you've just completed.**

