

ASTON CLINTON SURGERY  
 BEDGROVE SURGERY  
 WENDOVER HEALTH CENTRE

**HEALTH DATA FORM FOR WOMEN**

Present surname

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Forenames (*underline name by which usually known*)

Date of birth

DAY  MONTH  YEAR

Please list below any successful pregnancies

Year	Outcome	Sex of Child	Birth Weight

Any miscarriages or stillbirths?

Year	Miscarriage or Stillbirth	Stage of Pregnancy

Any terminations?

Year	Stage of Pregnancy

Are you now using contraception?  YES  NO

*\*Please give details:*

Condoms       Coil       Mini-Pill       Cap

Combined Contraceptive Pill       Injection       Other

Have you had a cervical smear?

YES  NO

When was your last smear?

Where?

What was the result?  Normal  Abnormal

*\*Please give details:*

Have you ever had an abnormal smear?

YES  NO

*\*Please give details:*

Have you had a mammogram?

YES  NO

When was your last mammogram?

Where?

What was the result?  Normal  Abnormal

*\*Please give details:*