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

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** _____

Fact Sheet

- 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

Fact Sheet

YOUR ALLERGIES

- Medication, food, iodine ❑ **YES** ❑ **NO**
  - **> If yes, which allergies?** _____

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**

Fact Sheet

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

Fact Sheet

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.**