Women's Obstetric & Gynaecology Specialists

Women's Obstetric and Gynaecology Specialists patient medical history

Please complete and return this form prior to your first appointment

Patient's name: **Partner's name:** *if applicable*

Date of birth: **First appointment date:**

Please tick if you are happy to receive test results by: ☐ SMS ☐ Email

Please list any allergies/reactions you have e.g. medicine, adhesive tape, foods	
Date of your last pap smear: / / **Pap smear result. Normal or abnormal?** (please circle as appropriate)	**Detail any treatment required:**
MEDICAL HISTORY **Please specify any past medical issues you've had and the treatment required** e.g. asthma, heart disease, gastrointestinal problems, kidney disease, urinary tract infection, epilepsy, thyroid disease, significant childhood illness	
PSYCHIATRIC HISTORY **Please specify any past psychiatric issues you've had and the treatment required** e.g. depression, anxiety, eating disorder, sleeping disorder, postnatal depression	
GYNAECOLOGICAL HISTORY **Please specify any past gynaecological issues and the treatment required** e.g. cervix abnormalities, fertility issues, investigations, polycystic ovary syndrome (PCO), pelvic inflammatory disease (PID), Sexually Transmitted Diseases (STDs)	
FAMILY HISTORY **Please specify any family history of illness for you and your partner** e.g. diabetes (Type 1/Type2), thyroid disease, heart disease, stroke, blood pressure problems, congenital/genetic disorders, psychiatric illness	

CURRENT MEDICATION Please list any medications you are taking, including prescription, over-the-counter, vitamins, folate	
Do you smoke? No/Yes **Amount per day:**	**Do you drink alcohol? No/Yes** **Amount per week:**
Have you had a blood transfusion? No/Yes **Year:** **Reason:**	
How would you describe your diet? E.g. vegetarian, vegan, healthy, unhealthy	
Do you exercise? No/Yes **If yes, what type and how often?**	
What is your height? cm	**What was your pre pregnancy weight? kg**

For new patients to complete

Previous pregnancies	Pregnancy 1	Pregnancy 2	Pregnancy 3	Pregnancy 4
Date				
Hospital				
Gestation (weeks)				
Outcome (e.g. healthy baby, miscarriage, termination)				
Labour (spontaneous/induced)				
Duration of labour				
Pain relief medication				
Birth type (e.g. normal, forceps, caesarean)				
Baby weight				
Baby name				
Feeding method				