MEDICAL HISTORY

Please complete and circle answer where necessary

1. NAME _____ **DATE** _____

2. AGE _____

3. Is this your first pregnancy? **YES** (If YES, go to 8) **NO**

4. Do you have any children? **YES** **NO** (If NO, go to 5)
How old are your children? ___ , ___ , ___ , ___ , ___ , ___ , ___ , ___ , ___ , ___
Are you breastfeeding? **YES** **NO**
How were the children born? **Vaginally** **Caesarean** **both**
Were there any complications? _____
_____
_____

5. Have you had any miscarriages? **YES** **NO** (If NO, go to 6)
How many miscarriages have you had? _____
Did any miscarriages require an operation in hospital? **YES** **NO**
When was the last miscarriage? _____
Were there any complications? _____
_____
_____

6. Have you ever had a termination of pregnancy? **YES** **NO** (If NO, go to 7)
When and where was the last termination? _____
Were there any complications? _____
_____

7. Have you ever had an ectopic pregnancy (in the Fallopian tube)? **YES** **NO**
If YES, what happened?
_____
_____

8. When was the first day of your last menstrual period? _____
Was this a normal period? **YES** **NO**
How often do you get a period? **28 days** **>28 days** **<28 days** **Irregular**
How many days do you bleed? **<5** **5-10** **>10**
How would you describe the amount of bleeding? **Mild** **Moderate** **Heavy**
How would you rate pain with periods? **None** **Mild** **Moderate** **Severe**

9. Was any form of contraception used when you fell pregnant? **YES** **NO**
If so, what contraception was used and why do you think it failed? _____
_____
Is there any contraception that interests you? If so, what? _____
_____
_____

10. Have you had any prior surgery requiring an anaesthetic? **YES** **NO**
What operations have you had?

_____

_____

Were there any problems with anaesthetics or relatives with problems? _____

11. Do you have or have had any of these medical problems**?** **Please circle**
Asthma diabetes epilepsy high blood pressure heart problems heart murmurs bleeding problems hepatitis B hepatitis C sexually transmitted infections depression other_____

_____

12. Do you take any medications? **YES** **NO**
What medications do you take? _____

_____

13. Do you have any allergies? **YES** **NO**
What allergies do you have and what happens? _____

14. What is your blood group, if known? _____

15. Have you had the Gardasil (cervical cancer vaccine) ? **YES** **NO**

16. Have you ever had a papsmear/CST (Cervical Screening Test)? **YES** **NO**
(Circle which test you have most recently had papsmear or CST)
When was your last papsmear/CST? _____
What was the result? _____

17. Do you smoke cigarettes? **YES** **NO**
How many cigarettes per day do you smoke? _____

18. Do you drink alcohol? **YES** **NO**
How often do you drink? **Every day** **once/week** **weekends** **monthly**

19. Do you take any other recreational drugs? **YES** **NO**
How often? **Every day** **once/week** **weekends** **monthly**

20. When was the last time you ate or drank anything? _____

21. How are you getting home today? _____

_____

22. Is someone taking you home today? **YES** **NO**
If so, who (first name)? _____
What relationship does this person have to you? _____
Contact phone number of support person? _____
Would you like this person to join you in recovery after the procedure? **YES** **NO**

23. Are there any questions that you would like to ask the doctor? _____

_____

_____

_____

All information is treated confidentially.
After completing this form you will have a consultation with the doctor and an opportunity to ask questions.
You are under no obligation to have the procedure performed today if you are not ready.