

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 currently 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 **YES** what contraception was used and why do you think it failed? _____

What contraception have you used in the past and what side effects (if any) did you have? _____

Is there any contraception that interests you? If **YES**, 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 sleep apnoea gastric reflux diabetes epilepsy high blood pressure
heart problems heart murmurs bleeding problems hepatitis B hepatitis C
sexually transmitted infections depression anxiety 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 any liquids other than water? _____

When was the last time you drank water? _____

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? _____

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.