

MEDICAL HISTORY

Please complete and circle answer where necessary

1. NAME _____ DATE _____

2. AGE _____ WEIGHT (kg) _____ HEIGHT (cm) _____

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. Can you climb a set of stairs without breathlessness? **YES** **NO**
13. Can you walk 2 blocks on level ground without breathlessness? **YES** **NO**

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

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

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

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

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

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

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

21. When was the last time you ate or drank any liquids other than water? _____
 When was the last time you drank water? _____

22. How are you getting home today? _____

23. 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? _____

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