

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? _____