MIRENA / IUD MEDICAL HISTORY

Please complete and circle answer where necessary

1. NAME _____ **DATE** _____

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

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

4. Have you had any miscarriages? **YES** **NO** (If NO, go to 5)
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? _____
_____

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

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

7. 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**

8. Are you using any form of contraception presently? **YES** **NO**
If so, what contraception are you using? _____
_____
_____

9. 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? _____

PLEASE TURN OVER and complete other side

10. 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 migraines
depression anxiety other _____
_____

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

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

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

15. 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 and what was result? _____
Have there ever been any abnormalities that required treatment? **YES** **NO**
Please describe _____
_____

16. Have you ever been treated with antibiotics for any pelvic infection? **YES** **NO**
Please describe _____
_____

**** IF YOU ARE HAVING THE IUD INSERTED UNDER INTRAVENOUS SEDATION, PLEASE ANSWER THE FOLLOWING QUESTIONS:***

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 any questions.