MEDICAL HISTORY

Please complete and circle answer where necessary

1. NAME _____ **TODAY's 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 migraines 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 pap smear/CST (Cervical Screening Test)? **YES** **NO**
(Circle which test you have had most recently - pap smear or CST)
When was your last pap smear/CST? _____
What was the result? _____

18. Do you smoke cigarettes (or vape)? **YES** **NO**
How many cigarettes (or vapes) per day? _____

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 any food 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? _____

_____

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.