

New Patient Medical History Form : Female

Name: _____ Age: _____

Height: _____ Weight: _____ Occupation: _____

Marital Status: Single Married De Facto Divorced Separated Other

Ethnicity: _____

Allergies: _____

Current Medications: _____

Supplements/ Vitamins: _____

Reason for visit: _____

How many caffeinated beverages (soft drink, tea, coffee, etc.) do you drink per day? _____

Do you smoke? No Yes _____ / packs per day. Have you quit? When? _____Do you drink alcohol? No Yes _____ / standard drinks per week.Do you use any recreational drugs? No Yes - Specify: _____
_____Do you exercise: No Yes - How often? _____Last pap smear: _____ History of abnormal pap smear? No YesHave you undergone any procedures as a result of an abnormal pap smear? _____
_____Have you ever had a mammogram? No Yes - Results? Normal Abnormal (explain)

Do you perform self-breast exams No Yes

Age at first period _____ Date of last two periods? (First date) 1. _____ 2. _____

Menstrual cycle pattern (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Regular periods | <input type="checkbox"/> Light periods |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Bleeding between periods |
| <input type="checkbox"/> Spotting before periods | <input type="checkbox"/> No periods |
| <input type="checkbox"/> Heavy periods | |

Do you know how long your cycle is (eg. 28 days)? _____ days

How many days of bleeding do you have? _____ days

Do you need medication to bring on a period? No Yes - What type? _____

If you do not have a period, at what age did you stop having them? _____ years old

Cramps? No Yes - Severity of the cramping? minimal moderate severe

Are Cramps always present? No Yes

Sexual History

How often do you have sexual intercourse? _____ times per week month

Lubricant used? No Yes - Brand(s): _____

Do you have pain with intercourse? No Yes

Have you ever been diagnosed with a sexually transmitted disease? No Yes

Pregnancy / Fertility History

Total number of ALL pregnancies: _____ Number of miscarriages (< 20 weeks): _____

Number of elective terminations: _____ Number of ectopic/ tubal pregnancies: _____

Number of full term deliveries: _____

Any pregnancies with complications? No Yes - Specify:

Of these pregnancies, were they with your current partner? No Yes

How long have you been trying to conceive? _____

Have you ever evaluated or treated for infertility before? No Yes

If yes, who was your physician? _____

Please provide any relevant medical history, including copies of relevant investigations, ultrasounds, blood tests and operations reports, for our records. Please let us know if a transfer medical records consent form is required.

Medical & Surgical History

Do you have any medical conditions? No Yes - Specify: _____

Do you know your blood type? No Yes - Specify: _____

Did you have any childhood illness? No Yes - Specify: _____

Have you ever had any surgery? No Yes - Specify: _____

Did you have any anaesthesia problems? No Yes

Family History

Any relevant medical family history? No Yes - Specify: _____

Vaccinations

Have you been vaccinated against the below?

Chickenpox (Varicella): Yes No Don't know

MMR - Measles, Mumps and Rubella: Yes No Don't know

Hepatitis A: Yes No Don't know

Hepatitis B: Yes No Don't know

Polio: Yes No Don't know

Whooping Cough: Yes No Don't know

Influenza: Yes No Don't know