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 ☐ Yes

Have 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):

☐ Regular periods
☐ Irregular periods
☐ Spotting before periods
☐ Heavy periods
☐ Light periods
☐ Bleeding between periods
☐ No 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