Sonia Anwar
GYNAECOLOGY

MBBS, MRMed, FRANZCOG

Name:_____ Date of Birth: / /

Are you? ☐ Single ☐ Married ☐ Defacto ☐ Divorced ☐ Widowed ☐ Same sex partner

ALLEGRY/ Sensitivity ☐ Nil known or: _____
Reaction: _____

Partner's Name: _____ Partner's DOB: / /

Partner's Occupation: _____

Medical History: Do you have, or have you ever had:

☐ Asthma	☐Diabetes Type 1	☐Hepatitis A, B, C	☐Mitral valve prolapse
☐ Autoimmune disorder	☐Diabetes Type 2	☐Hearing/vision impaired	☐Migraines
☐ Anxiety/ depression	☐Diabetes gestational		☐Osteoporosis
☐ Anaemia	☐Eating disorder	☐Herpes	☐Pelvic inflammatory disease
☐ Bleeding disorder	☐Endometriosis	☐Infertility	☐Seizures
☐ Blood transfusion	☐Fibroids	☐IBS	☐Sexual transmitted infection
☐ Bone/joint disorder	☐GERD/ Reflux	☐HIV	☐Sleep apnoea
☐ Breast problems	☐GI Illness	☐HPV/genital warts	☐Thyroid disorder
☐ COAPD/emphysema	☐High cholesterol	☐High blood pressure	☐TB
☐ Ectopic pregnancy	☐Heart murmur	☐Liver disease	☐Trauma
☐ DVT/ Stroke	☐Heart disease	☐Kidney disease	☐Urinary incontinence
☐ Cancer (type)_____	☐Jehovah Witness	☐Miscarriage	☐UTI's

☐ Other medical problems/ comments_____

Surgical History: Please list ALL surgical procedures, including year & name of hospital:

_____
_____
_____
_____

Medicines: Current medications & dosage _____

_____
_____
_____
_____
_____

Anaesthesia Complications: Tick those that apply –

☐ Malignant Hyperthermia
☐ Excessive difficulty waking up
☐ Difficult Intubation

Vitamins & supplements_____
_____
_____

Sonia Anwar
GYNAECOLOGY

MBBS, MRMed, FRANZCOG

Do you currently?

Smoke Cigarettes	☐No	☐Yes	How many per day …….
Drink Alcohol	☐No	☐Yes	Type …… How much per day ……....
Use illicit drugs	☐No	☐Yes	Type …….. How often……..
Exercise	☐No	☐Yes	Type …….. How often……..

Family History: (*Mother, Father, Sister, Brother, Grandmother, Grandfather, Other Relative*)

Do any of your blood relatives have/ had any illness listed below? ☐ No ☐ Yes ☐ I'm Adopted

Other Give details of illness or cancer.

☐ Cancer	☐ Diabetes	If "yes" to any, tick and list affected family members
☐ Blood disorders	☐ Heart Disease	_____
☐ Osteoporosis	☐ Arthritis	_____
☐ Hypertension	☐ Kidney Disease	_____
☐ DVT	☐ Stroke	_____
☐ Endometriosis	☐ Genetic diseases	_____

Other Give details of Illness or Cancer _____

Baseline Observations: Complete only if known

BP	Weight	Height	BMI
/	kg	cm	

Gynaecological History:

Approximate Age at first period? _____

How often do you get your menstrual cycle? Every_____days, lasting_____days

Are your cycles? …… ☐ Regular ☐ Irregular

Is your menstrual flow …… ☐ Light ☐ Moderate ☐ Heavy ☐ Clots

How many pads/ tampons used on heaviest day? _____

Does bleeding or spotting occur ……☐ Between periods? ☐ After intercourse?

Is pain associated with your period? …… ☐No ☐Yes ☐Occasionally

If "yes" is the pain …… ☐Before ☐During ☐Both

Describe the amount of discomfort…….. ☐Mild ☐Moderate ☐Severe

Other premenstrual issues? ☐ Back pain ☐ Bloating ☐ Cramps ☐Sore Breasts ☐ Moodiness

If menopausal, age of menopause? _____

Have you had bleeding or spotting since menopause? …… ☐No ☐Yes

Sonia Anwar
GYNAECOLOGY

MBBS, MRMed, FRANZCOG

Contraceptive and Sexual History:

Current Method of contraception:

☐ None ☐ Vasectomy ☐ The Pill ☐ Mirena ☐ Implanon ☐ Tubal ligation
☐ Condoms ☐ Nuva ring ☐ Rhythm Method ☐ IUD ☐ Essure ☐ Depo provera
☐ Other

Have you ever been sexually active?	☐ No	☐ Yes
Have you had a new sexual partner in the past 3 months?	☐ No	☐ Yes
How many partners have you had in the last 6 months? _____		
Is/ Are your partner(s) ..... ☐Male	☐ Female	☐ Both
Do you experience pain or discomfort with sexual intercourse?	☐ No	☐ Yes
Would you like to discuss sexual activity or birth control today?	☐ No	☐ Yes
Have you been a victim of physical, verbal, emotional or sexual abuse?	☐ No	☐ Yes

Pap Smear History:

Date of last Pap smear: / / Was this result normal?	☐ No	☐ Yes
Have you ever had an abnormal pap smear?	☐ No	☐ Yes
Have you had treatment for abnormal pap smear?	☐ No	☐ Yes
If yes, what treatment? ☐Unsure Repeat pap	☐Colposcopy	☐LLETZ/Cone
Have your Gardasil vaccination series been completed?	☐ No	☐ Yes
Do you have any Breast problems	☐ No	☐ Yes
Date of last mammogram: / /	☐ NA	
Have you had an abnormal mammogram?	☐ No	☐ Yes
Have your Gardasil vaccination series been completed?	☐ No	☐ Yes

Sonia Anwar
GYNAECOLOGY
MBBS, MRMed, FRANZCOG

Obstetric History:

How many times have you been pregnant? _____ How many children do you have? _____

Please list all pregnancies, including miscarriages, ectopic and terminations

Baby's Name	DOB	Duration of pregnancy (wks)	Length of Labour	Baby's Birth Weight	Sex	Type Of Delivery *vaginal, C/S forceps vacuum*	Anaesthesia *Epidural, local spinal, general*	Complications Mother And/ or Infant *preterm Labour, diabetes, bleeding, high BP, postpartum depression*	Place of delivery or termination

The information provided by me is, to the best of my knowledge, correct at the time of completing.

Patient's Signature: _____ *Date* / /