Launceston Obstetrics & Gynaecology

Patient Medical History

Please complete and return this form prior to your first appointment.

Patient Name: **Partner's name:**

Date of birth: **Appointment Date:**

Covid 19 vaccination status: (circle) fully & current partly not vaccinated

Allergies/Reactions: Nil / Yes details below (medicines/adhesive tapes/foods)

Last PAP Smear: Date / / normal / abnormal (circle)

Past Medical History Nil / Yes (details below)

e.g. Asthma, Heart Disease, Gastrointestinal problems, Kidney disease/UTI, Epilepsy, significant childhood illnesses

Treatment required:

Past Surgical History Nil / Yes (details below)

Local or general anaesthetic

Past Gynaecological History: Nil / Yes (details below)

Cervix abnormalities, Fertility issues, Investigations, PCO, PID

Treatment required

Past Psychiatric History Nil / Yes (details below)

e.g. Depression/Anxiety, Eating/Sleeping Disorders, Postnatal Depression

Family History Nil / Yes (details below)

Diabetes (T1/T2), Thyroid Disease, Heart Disease, Stroke, Blood Pressure problems, Congenital/Genetic Disorders, Psychiatric illness

Current Medications Nil / Yes (details below)

Please include any prescription/ over the counter/ vitamins/ folate that you are taking currently

Do you smoke? No / Yes (amount)	Do you drink alcohol? No / Yes (amount)
Ever had a blood transfusion?	No / Yes (year) Reason:
Do you exercise?	No / Yes (type)
What is your height? cm	What was your pre-pregnancy weight? kg

Previous Pregnancies (new patients only)	Pregnancy 1	Pregnancy 2	Pregnancy 3	Pregnancy 4
Date				
Place (name of hospital)				
Gestation in weeks				
Outcome: (Livebirth / Miscarriage / TOP)				
Labour (spontaneous / Induced)				
Duration of labour				
Analgesia				
Birth Type (e.g. Normal / forceps/ caesarian)				
Baby weight / sex				
Baby name				
Feeding Method				