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:**

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					