Wollongong
OBSTRETRICS & GYNAECOLOGY
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Obstetrician, Gynaecologist & Laparoscopic Surgeon

Please complete and return this form prior to your first appointment

ALLERGIES/REACTIONS:	**NIL/YES - details below**	(MEDICINE/ADHESIVE TAPES/FOODS)
LAST PAP SMEAR: DATE / /	Normal or Abnormal (circle)	TREATMENT:

PAST MEDICAL HISTORY:	**NIL/YES - details below**
eg. Asthma, Heart Disease, Gastrointestinal problems, Kidney Disease/UTI, Epilepsy, Thyroid Disease, Significant childhood illnesses.	
PAST PSYCHIATRIC HISTORY:	**NIL/YES - details below**
eg. Depression/Anxiety, Eating/Sleeping Disorders, PND.	
PAST SURGICAL HISTORY:	**NIL/YES - details below**
Local or General Anesthetic.	
PAST GYNAECOLOGICAL HISTORY:	**NIL/YES - details below**
eg. Cervix abnormalities, Fertility issues, Investigations, PCO, PID.	
FAMILY HISTORY:	**NIL/YES - details below**
eg. Diabetes(T1/T2), Thyroid Disease, Heart Disease, Stroke, Blood Pressure problems, Congenital/Genetic Disorders, Psychiatric illness.	
CURRENT MEDICATION:	**NIL/YES - details below**
eg. Please include any prescription/over the counter/vitamins/folate that you are currently taking.	

DO YOU SMOKE? NO/YES **Amount**:	**DO YOU DRINK ALCOHOL?** NO/YES **Amount**:
HAVE YOU EVER HAD A BLOOD TRANSFUSION?	NO/YES Year: Reason:
WHAT SORT OF DIET DO YOU HAVE?	
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 (weeks)				
Outcome (eg. Live birth/Miscarriage/TOP)				
Labour (eg. Spontaneous/Induced)				
Duration of Labour				
Analgesia				
Birth Type (eg. normal/forceps/caesarean)				
Baby Weight				
Baby Sex				
Baby Name				
Feeding Method				