

Gynaecology Questionnaire

Personal Particulars

Name: (Mr, Mrs, Ms, Miss, Other _____) First: _____ Last: _____

Home/Postal Address: _____

Suburb: _____ Postcode: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Your Occupation: _____ Employer: _____ Marital Status: _____

Partner's Name: _____ Partner's DOB: _____ Partners Mobile: _____

Partner's Occupation: _____ Partner's Employer: _____

Medical History

- Deep venous thrombosis
- Gynaecological problems
- Kidney Disease
- Alcohol (drinks _____ per week)
- Diabetes
- Heart disease
- Asthma/respiratory disease
- Smoking (number per day)
- Epilepsy
- High blood pressure
- Thyroid disorders
- Illicit drug use

Medication history (including over the counter)

Medications	Dose	Frequency	Cessation

Allergies (detail all including reactions to medication)

Allergies

Please continue...

Gynaecology Questionnaire

Surgical history

Anaesthetic history

Dental health & jaw problems
Back problems
Blood transfusion
Other

Past pregnancy information

to indicate sensitive information not recorded here. Age ____ Gravidity ____ Parity ____

✓	Date	Place	Gestation	Labour, birth & postnatal details	Birth Weight	Gender	Feeding Type & Duration	Babys Name

Psycho - Social History

- Anxiety/depression
- Emotional issues
- Relationship issues
- Financial issues
- Postnatal depression
- Major stressors, life changes or losses
- Contact with Families SA
- Other
- Other psychiatric disorders
- Mental health problems
- Accommodation issues

Family History

Diabetes _____

Heart Disease _____

High Blood Pressure _____

Genetic Disorders / Congenital Abnormalities _____

Other _____

Please tell us the reason/s for your visit: _____

How did you find out about North Adelaide Obstetrics + Gynaecology?

This information is strictly confidential, once entered into your file, this document will be destroyed.