



# Obstetric Questionnaire

## Medication history (including over the counter)

Medications	Dose	Frequency	Cessation

## Allergies (detail all including reactions to medication)

Allergies

## Surgical history

## Anaesthetic history

Previous anaesthetic problems \_\_\_\_\_

Dental health & jaw problems \_\_\_\_\_

Back problems \_\_\_\_\_

Blood transfusion \_\_\_\_\_

Other \_\_\_\_\_

## Psycho - Social History

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anxiety/depression  | <input type="checkbox"/> Postnatal depression                    | <input type="checkbox"/> Other psychiatric disorders |
| <input type="checkbox"/> Emotional issues    | <input type="checkbox"/> Major stressors, life changes or losses | <input type="checkbox"/> Mental health problems      |
| <input type="checkbox"/> Relationship issues | <input type="checkbox"/> Contact with Families SA                | <input type="checkbox"/> Accommodation issues        |
| <input type="checkbox"/> Financial issues    | <input type="checkbox"/> Other                                   |  |

## 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.**