DrMeganByrnes
Obstetrician and Gynaecologist

Joondalup Private Hospital
Suite 10 Specialist Medical Centre East
Shenton Ave, Joondalup, WA 6027

Name: _____ Date of Birth: _____

ALLERGY / SENSITIVITY

☐ Nil known or: _____

Reaction: _____

Are you? ☐ Single ☐ Married ☐ Defacto ☐ Divorced ☐ Widowed ☐ Same sex partner

Partners Name: _____ Date of Birth: _____

Medical History Do you have or have you ever had -

- ☐ Asthma
- ☐ Autoimmune disorder
- ☐ Anxiety / Depression
- ☐ Anaemia
- ☐ Bleeding disorder
- ☐ Blood transfusion
- ☐ Bone / Joint disorder
- ☐ COPD / Emphysema
- ☐ Ectopic pregnancy
- ☐ DVT / Stroke
- ☐ Cancer (type) _____
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Diabetes gestational
- ☐ Eating disorder
- ☐ Endometriosis
- ☐ Fibroids
- ☐ GERD / Reflux
- ☐ GI Illness
- ☐ High cholesterol
- ☐ Heart murmur
- ☐ Heart disease
- ☐ Hepatitis A, B, C
- ☐ Hearing / Vision Impaired
- ☐ Herpes
- ☐ IBS
- ☐ Infertility
- ☐ HIV
- ☐ HPV / Genital warts
- ☐ High blood pressure
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Miscarriage
- ☐ Mitral valve prolapse
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pelvic inflammatory disease
- ☐ Seizures
- ☐ Sexually transmitted infection
- ☐ Sleep apnoea
- ☐ Thyroid disorder
- ☐ TB
- ☐ Urinary incontinence
- ☐ UTI's

☐ Other medical problems / comments _____

Surgical History Please list all surgical procedures, including year & name of hospital -

_____

_____

_____

Medicines
Current medications & dosage -

_____

_____

_____

Anaesthesia Complications Tick those that apply –

- ☐ Malignant Hyperthermia
- ☐ Excessive difficulty waking up
- ☐ Difficult Intubation

Vitamins & supplements -

_____

_____

_____

Do you currently?

Smoke cigarettes	☐ No ☐ Yes	How many per day _____		
Drink alcohol	☐ No ☐ Yes	Type _____	How much per day _____	
Use illicit drugs	☐ No ☐ Yes	Type _____	How often _____	
Exercise	☐ No ☐ Yes	Type _____	How often _____	

Family History (Mother, Father, Sister, Brother, Grandmother, Grandfather, Other Relative)

Do any of your blood relatives have/ had any illness listed below? ☐ No ☐ Yes ☐ I'm Adopted

- ☐ Cancer
- ☐ Blood disorders
- ☐ Osteoporosis
- ☐ Hypertension
- ☐ DVT
- ☐ Endometriosis
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Arthritis
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Genetic diseases
- ☐ Other Give details of illness or cancer.

If '**yes**' to any, tick and list affected family members

_____

_____

_____

BASELINE OBSERVATION

Complete only if known

Weight Kg	Height cm	BMI

Gynaecological History

Approximate age at first period?	_____				
How often do you get your menstrual cycle?	Every _____ days, lasting _____				
Are your cycles?	☐ Regular	☐ Irregular			
Is your menstrual flow?	☐ Light	☐ Moderate	☐ Heavy	☐ Clots	
How many pads/ tampons used on heaviest day?	_____				
Does bleeding or spotting occur	☐ Between periods?	☐ After intercourse?			
Is pain associated with your period?	☐ No	☐ Yes	☐ Occasionally		
- if '**yes**' is the pain	☐ Before	☐ During	☐ Both		
- Describe the amount of discomfort	☐ Mild	☐ Moderate	☐ Severe		
Other premenstrual issues?	☐ Back pain	☐ Bloating	☐ Cramps	☐ Sore Breasts	☐ Moodiness
If menopausal, age of menopause?	_____				
Have you had bleeding or spotting since menopause?	☐ No	☐ Yes			

Contraceptive and Sexual History ☐ N/A

Current Method of contraception	☐ None	☐ Vasectomy	☐ The Pill	☐ Mirena	☐ Implanon
	☐ Condoms	☐ Nuva ring	☐ Rhythm Method	☐ IUD	☐ Essure
	☐ Other	☐ Tubal ligation	☐ Depo provera		

Have you ever been sexually active?	☐ No	☐ Yes
Have you had a new sexual partner in the past 3 months?	☐ No	☐ Yes
How many partners have you had in the last 6 months?	_____	
Is/ Are your partner(s)	☐ Male	☐ Female ☐ Both
Do you experience pain or discomfort with sexual intercourse?	☐ No	☐ Yes
Have you been a victim of physical, verbal, emotional or sexual abuse?	☐ No	☐ Yes

Cervical Screen Test History

Date of last Cervical Screen Test _____	Was this result normal?	☐ No	☐ Yes	
Have you ever had an abnormal Cervical Screen Test?	☐ No	☐ Yes		
Have you had treatment for abnormal Cervical Screen Test?	☐ No	☐ Yes		
if '**yes**', what treatment	☐ Unsure	☐ Repeat Screen	☐ Colposcopy	☐ LLETZ/Cone
Have your Gardasil vaccination series been completed?	☐ No	☐ Yes		
Do you have any breast problems?	☐ No	☐ Yes		
Date of last mammogram _____	☐ NA			
Have you had an abnormal mammogram?	☐ No	☐ Yes		

Obstetric History

How many times have you been pregnant? _____ How many children do you have? _____

Please list all pregnancies, including miscarriages, ectopic and terminations

Baby's name	DOB	Duration of pregnancy (wks)	Length of labour	Baby's birth weight	Sex	Type of delivery *vaginal, C/S forceps, vacuum*	Anaesthesia *Epidural, local spinal, general*	Complications mother and/ or infant *preterm labour, diabetes, bleeding, high BP, postpartum depression*	Place of delivery or termination

The information provided by me is, to the best of my knowledge, correct at the time of completing.

Patients Signature _____ Date _____