AURORA WOMEN'S HEALTH

Dr Anu Kaur
St Andrew's Place, Level 2,
33 North St, Spring Hill, QLD 4000

Name: _____ Date of Birth: / /

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

ALLEGRY/ Sensitivity ☐Nil known or: _____
Reaction: _____

Partner's Name: _____ Partner's DOB: / /
Partner's Occupation: _____

Medical History: Do you have or have you ever had –

☐Asthma	☐Diabetes Type 1	☐ Hepatitis A, B, C	☐ Mitral valve prolapse
☐Autoimmune disorder	☐Diabetes Type 2	☐ Hearing/vision impaired	☐ Migraines
☐Anxiety/ depression	☐Diabetes gestational		☐ Osteoporosis
☐Anaemia	☐Eating disorder	☐ Herpes	☐ Pelvic inflammatory disease
☐Bleeding disorder	☐Endometriosis	☐ Infertility	☐ Seizures
☐Blood transfusion	☐Fibroids	☐ IBS	☐ Sexual transmitted infection
☐Bone/joint disorder	☐GERD/ Reflux	☐ HIV	☐ Sleep apnoea
☐Breast problems	☐GI Illness	☐ HPV/genital warts	☐ Thyroid disorder
☐COAPD/emphysema	☐High cholesterol	☐ High blood pressure	☐ TB
☐Ectopic pregnancy	☐Heart murmur	☐ Liver disease	☐ Trauma
☐DVT/ Stroke	☐Heart disease	☐ Kidney disease	☐ Urinary incontinence
☐Cancer (type)_____	☐Jehovah Witness	☐ Miscarriage	☐ 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	☐Diabetes
☐Blood disorders	☐Heart Disease
☐Osteoporosis	☐Arthritis
☐Hypertension	☐Kidney Disease
☐DVT	☐Stroke
☐Endometriosis	☐Genetic diseases

☐Other Give details of illness or cancer.

If "yes" to any, tick and list affected family members
_____
_____
_____
_____
_____
_____

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Baseline Observations: Complete only if known

BP	Weight	Height	BMI
/	kg	cm	

Gynaecological History:

Approximate Age at first period? _____

How often do you get your menstrual cycle? Every _____days, lasting _____days

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:

Current Method of contraception:

☐None ☐Vasectomy ☐The Pill ☐Mirena ☐Implanon ☐Tubal ligation

☐Condoms ☐Nuva ring ☐Rhythm Method ☐IUD ☐Essure ☐Depo provera

☐Other

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

Would you like to discuss sexual activity or birth control today? ..... ☐No ☐Yes

Have you been a victim of physical, verbal, emotional or sexual abuse? ☐No ☐Yes

Pap Smear History:

Date of last Pap smear: / / Was this result normal? ☐No ☐Yes

Have you ever had an abnormal pap smear? ☐No ☐Yes

Have you had treatment for abnormal pap smear? ☐No ☐Yes

If yes, what treatment? ☐Unsure ☐Repeat pap ☐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.

Patient's Signature _____ *Date* / /

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This section to be completed if you are pregnant

Name: _____ Date of Birth: / /

Father of Baby's Name: _____ Father of baby's Date of Birth: / /

How old will you be by your due date? _____

First day of your last menstrual period / /
Was it normal? ☐Yes ☐No

How far apart are your menstrual periods? _____ Days Are they ☐regular or ☐irregular?

Has this pregnancy been confirmed with an ultrasound ☐No ☐Yes
If 'yes', where did you have it? _____

Have you had any blood tests with this pregnancy ☐No ☐Yes
If 'yes', details of pathology lab _____

Was this pregnancy conceived on birth control pills? ☐No ☐Yes

Is this pregnancy the results of fertility treatment? ☐No ☐Yes
If 'yes', give details _____

With this pregnancy have you had:

Nausea?	☐None	☐Mild	☐Moderate	☐Severe
Bleeding?	☐None	☐Spotting	☐Light	☐Clots
Urinary Tract Infections?	☐No	☐Yes		

Do you own a cat? ☐No ☐Yes If 'yes', who changes the litter box? _____

Have you been vaccinated against: ☐chicken pox ☐Hepatitis B ☐Whooping Cough?

Have you, the baby's father or any blood relative had?

☐Downs Syndrome	☐Neural Tube defect (spina bifida, anencephaly)?	☐Muscular Dystrophy
☐Cystic Fibrosis	☐Haemophilia or other blood disorders?	☐Chromosomal abnormality
☐Thalassemia	☐Huntington's Chorea	☐Diabetes
☐Tay Sachs disease	☐Child who died before birth or shortly after	☐Other birth defects
☐Twins/ Triplets	☐History of miscarriage	

If 'yes', give details: _____

Baseline Observations: Complete only if known

EDC	BP	Weight	Height	BMI
/ /	/	kg	cm	

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Patient's Signature _____ *Date* / /

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