**PATIENT DETAILS (confidential)**

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| --- | --- | --- | --- | --- |
| **Personal Information:** | | | | |
| Title: Miss  Mrs  Ms  Other | | Date of Birth:       /       / | | |
| Given Names: | | Surname: | | |
| Previous Surname (if any): | | Occupation: | | |
| Do you identify as Aboriginal Yes  No | | Torres Strait Islander: Yes  No | | |
| **Contact Information:** | | | | |
| Residential Address: | | | | |
|  | | | Postcode: | |
| Home Ph: | Work Ph: | | Mobile Ph:  May we send SMS? Yes  No | |
| Email Address: | | |
| **Partner Details:** | | | | |
| Name: | | DOB: | | |
| Occupation: | Work Ph: | | | Mobile Ph: |
| **Next of Kin:** | | | | |
| Name: | | Relationship: | | |
| Work Ph: | | Mobile Ph: | | |
| **Medicare Details:** | | | | |
| Card No: | Prefix No:  *(Number in front of your name)* | | | Valid to:      / 20 |
| **Health Fund Insurance: Yes**  **No** | | | | |
| Health Fund: | Membership No: | | | Prefix No: |
| Health Fund Cover: Gold  Silver  Bronze | | | | |
| Have you changed/joined health fund in the last 12 months? Yes  No | | | | |
| **Veteran Affairs: Yes**  **No** | | | | |
| Card No: | | Card Type: | | |

**Privacy:** I understand this Practice has a privacy policy for handling patient information. The Privacy Statement is available on request. I understand I am not obliged to provide any information to this practice but that it assists in providing quality health care. I have the right to access the information collected about me and I consent to use of this information for health care, administration, medical defence purposes, billing and disclosure to other health care professionals involved in my care.

|  |  |
| --- | --- |
| **Signature:** | **Date:** |

**Please Complete All of This Questionnaire**

|  |  |
| --- | --- |
| What was the date of your last period? | **/      /** |
| How many days is it from the start of one period until the next? |  |
| How many days to you bleed for? |  |
| When was your last Cervical Screening Test? (Pap smear) | **/      /** |
| Where was this performed |  |
|  | |
| **Do you:** |  |
| 1. Have any bleeding between periods? | Yes  No |
| 2. Have any unusual vaginal discharge? | Yes  No |
| 3. Have painful periods? | Yes  No |
| 4 Experience pain with intercourse? | Yes  No |
| 5. Have problems passing urine? | Yes  No |
| 6. Need to go “right now” when passing urine? | Yes  No |
| 7. Experience urine incontinence when coughing, sneezing, etc? | Yes  No |
| 8. Have any problems with bowel motions e.g. constipation/diarrhoea? | Yes  No |
|  | |
| Have you had any testing recently, e.g. blood tests, ultrasounds, X-Rays  IN RELATION TO THIS APPOINTMENT? | Yes  No |
| When and where were these performed? |  |
|  | |
| **Contraception:** What kind of contraception do you use? |  |
|  | |
| **Obstetric History:** |  |
| 1. How many pregnancies have you had? |  |
| 2. How many vaginal deliveries? |  |
| 3. How many caesarean sections? |  |
| 4. How many miscarriages: |  |
| Have you had any operations? | Yes  No |
| **If yes, please list:** |  |
|  | |
| Are you on any medication? | Yes  No |
| **If yes, please list:** |  |
| Have you ever undergone a blood transfusion? | Yes  No |
| **If yes, when:** | **/      /** |
| Do you have any know drug allergies? | Yes  No |
| **If YES, what drugs are you allergic to:** |  |
| Do you smoke? | Yes  No |
| **If yes, how many per day:** |  |
| Would you drink more than three standard Alcoholic drinks per day? | Yes  No |
| **If yes, how many per day:** |  |
|  | |
| **Family History** |  |
| Is your mother - Alive and Well Deceased  Cause of Death |  |
| Is your father - Alive and Well Deceased  Cause of Death |  |
| Is there any other relevant information that you feel would be important for the doctor to be aware of? |  |
| **Signature:** | **Date:     /     /** |