**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:     /     /** |