Bayside Obstetrics & Gynaecology

Suite 15, Level 1, Mater Health Centre, 16 Weippin St, Cleveland, QLD 4163.
Ph: 3163 7424 Fax: 3163 7425

Patient Personal Details

Mrs/Ms/Miss/Dr Surname_____

Given Name_____ Date of Birth_____

Phone Home (__)_____ Work(__)_____

Mobile_____ Email Address_____

Street Address_____

_____ Post Code _____

Occupation _____

Next of Kin/Partner _____ Relationship _____

Contact No _____

COVID VACCINE: YES NO

HEALTHCARE COVER:

Medicare No: __ __ __ __ __ __ __ __ __ __ Ref No: ____ Expiry: _____ /_____

Pension No: _____ Expiry: _____ /_____

DVA No: _____ Expiry: _____ / _____

Yes / No Do you have current Private Health Insurance Cover? Is your cover overseas Health Cover?

Health Fund: _____ Membership No: _____

Yes / No Have you held your **Hospital** cover with your Private Health Fund for more than 12 months?

Yes / No Does your Private Health Fund Insurance cover you for **Obstetrics?**

Yes / No Does your Private Health Insurance cover you for Mental Health Services?

****** If you are anticipating hospitalisation and / or surgery. Please check full details of your health cover with your Private Health Insurance Company ******

PERSONAL MEDICAL HISTORY:

Please circle Yes or No if you have any of the following medical problems.

Heart Disease	**Yes**	**No**	Depression/Anxiety	**Yes**	**No**	Breast Problems	**Yes**	**No**
Diabetes	**Yes**	**No**	Anorexia/Bulimia	**Yes**	**No**	Urinary Tract Infection	**Yes**	**No**
Heart Murmurs	**Yes**	**No**	High Blood Pressure	**Yes**	**No**	Endometriosis	**Yes**	**No**
Kidney Disease	**Yes**	**No**	Asthma	**Yes**	**No**	Sexually Transmitted Disease	**Yes**	**No**
Seizures	**Yes**	**No**	Hepatitis	**Yes**	**No**	History of Ectopic Pregnancy	**Yes**	**No**
Skin Disorders	**Yes**	**No**	Arthritis	**Yes**	**No**	Uterine Fibroids	**Yes**	**No**
Intestinal Problems	**Yes**	**No**	Cancer	**Yes**	**No**	Thyroid Disease	**Yes**	**No**
High Cholesterol	**Yes**	**No**	Tuberculosis	**Yes**	**No**	Osteoporosis	**Yes**	**No**
Jaundice (yellowing Of the skin)	**Yes**	**No**	Migraines	**Yes**	**No**	Blood Transfusions	**Yes**	**No**
DVT (Blood Clots)	**Yes**	**No**	Anaemia/Blood Disease	**Yes**	**No**	Jehovah Witness	**Yes**	**No**
Vision or Hearing Impairment	**Yes**	**No**	Mitral Valve Prolapse	**Yes**	**No**			

FAMILY HISTORY: Please place a tick in the box of the blood related relatives that have the following.

CONDITION	MOTHER	FATHER	BROTHER	SISTER	GRANDPARENTS
Diabetes					
Heart Disease					
High Blood Pressure					
DVT (Blood Clots)					
Cancer					

CURRENT MEDICATIONS: Please list all Medications & Dosage you are currently taking.

ALLERGIES: Please list all Medications from which you have had an allergic reaction.

PREVIOUS SURGERY

Year	Surgery	Year	Surgery

GYNAECOLOGICAL HISTORY:

1. Menstrual History:

(a) How old were you when your periods first started? _____

(b) How many days apart are your periods? _____

(c) How many days does your period last? _____

(d) Do you have cramping or pain? _____

(e) Is your flow light, medium, heavy? _____

(f) Are you currently having problems with your period? _____

2. Pap Smear History:

(a) When was your last pap smear? _____

(b) Was it normal? _____

(c) Have you ever had an abnormal pap smear? _____

(d) If **YES**, what was done? _____

3. Breast History

(a) Have you ever had any breast problems? _____

(b) When was your last mammogram? _____

(c) Have you ever had an abnormal mammogram? _____

OBSTETRICAL HISTORY:

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

Month&Year Of birth	Gestational Age	Labour	Delivery Type	Weight	Sex	Name	Remarks

SOCIAL HISTORY:

Marital Status: Single Married Widow Divorced De Facto

Partners Name _____ Partners DOB _____ Vasectomy: **Yes** or **No**

Partners Occupation _____

Do you smoke? **Yes** or **No** How many per day? _____

How much Alcohol do you consume per day? _____

Are you currently sexually active? _____

Are you currently using any type of birth control? _____

Consent & Release Of Medical Information

I give consent to Bayside Obstetrics & Gynaecology to contact any of my previous medical practitioners or hospitals to obtain previous health records that are relevant to my current care.

Website page is: www.baysideog.com.au and Facebook page is: facebook.com/BaysideOG

I authorise those previous practitioners and hospitals to release such information, even sensitive health records, to Bayside Obstetrics & Gynaecology as requested.

How did you hear about us? □ GP referral □ Website/Google □ Cinema Advert □ Facebook □ Referred by a friend

I understand that during my consultation it may be necessary for minor procedures to be performed and I consent to those procedures being carried out after suitable consultation with myself.

Patient Signature_____ Date ____/____/_____