Health Questionnaire for Gynecological Patients

Name: _____

DOB: _____ Date: _____

History:

Medical History	**Yes**	**No**	**Additional Information**
Diabetes			
Epilepsy			
Clots in legs/lungs			
High Blood Pressure			
Heart problems			
Kidney/Liver problems			
Thyroid problems			
Gynecological problems			
Back problems			
Depression			
Infertility Treatment			
Have you had a general anesthesia			
Did you have any problems?			
Any other relevant Medical/Surgical History			
Last Pap smear date:			
Any abnormal Pap Smears?			
Any known Infectious Diseases?			

Current Symptoms: Reason for referral (also any other concern)

Menstrual History	
How often do you have a period? (length of cycle)	
Days of bleeding each cycle	
Date of first day of last period	
Are your periods regular?	

Contraception-
Are you using any contraception?
Type

Obstetric History

DOB	**Delivery Type**	**Birth Weight/Sex**

Family History	**Yes**	**No**	**Additional Information**
Diabetes			
Heart Disease			
High Blood Pressure			
Cancer			
Congenital abnormalities			
Genetic Illnesses			
Any other conditions			

Social History	Yes	No	Additional Information
Drug Allergies			
Non drug Allergies			
Smoker			
Alcohol			

Please List any operations and year:

Type of Operation	Year

Please list Current medications and dosages:

Name	Dosage

PERSONAL DETAILS

Title _____Given Name: _____ Surname:_____

Address: _____Postcode: _____

Postal Address: _____Postcode: _____

Date of Birth: _____ Home Phone: _____

Work Phone: _____ Mobile Phone: _____

Email: _____

Occupation: _____

Next of Kin: _____ Relationship:_____

Next of Kin Contact Number: _____

Current GP: _____

Medicare Number: _____Ref: _____ Expiry: _____

Health Fund: _____Membership Number: _____

Special Interest: _____

How did you hear about us? GP/Specialist /Advertising /Friend/Family /Google /Internet

Other:_____

CONSENT TO RELEASE OF MEDICAL INFORMATION

I give my consent to NG Gynehealth, or their agents and advisors, to contact medical practitioners or other bodies I have consulted to obtain health and other information that may be pertinent to my care.

I authorize those medical practitioners or bodies to release such information, which may include sensitive health information, to NG Gynehealth, or their agents and advisors, as may be requested.

I understand that unless I advise otherwise, NG Gynehealth will continue to liaise with the doctors nominated above on matters related to my ongoing care.

OTHER

I give permission for NG Gynehealth to contact me via SMS/Phone regarding appointment details and results.
I give permission for NG Gynehealth to contact me through email.
I give permission to NG Gynehealth to take clinical photographs and use them for educational purposes.
I give permission to NG Gynehealth to take identification photographs to attach to my clinical chart.
I understand it is my responsibility to call the clinic for results**.**

Privacy Statement

Your information will be kept confidential in this practice at all times. All our staff are governed by the Policy Act of 1988. If you have any concern regarding your privacy being disclosed, please discuss this with your Doctor.

I consent to the collection and release of personal information about me to other healthcare professionals when it is relevant to my health and care.

Signature: _____ Date: _____