PATIENT HISTORY SHEET(OBS)

MENSTRUAL HISTORY

WHEN WAS THE FIRST DAY OF YOUR LAST PERIOD?……..

WAS THAT PERIOD NORMAL?…….

REGARDING YOUR CYCLE: HOW MANY DAYS FROM THE 1ST DAY OF ONE PERIOD TO THE 1ST DAY OF THE NEXT?……

IS IT REGULAR?…….

HAVE YOU RECENTLY BEEN ON THE CONTRACEPTIVE PILL?……..

IF SO WHEN DID YOU CEASE IT?……...

HAVE YOU EVER HAD SIGNIFICANT PROBLEMS WITH YOUR PERIODS?……..

IF SO DESCRIBE THESE PLEASE…….

HAVE YOU HAD A DATING ULTRASOUND SCAN YET?…… IF SO HOW MANY

WEEKS PREGNANT WERE YOU WHEN YOU HAD IT?……

PAST PREGNANCY HISTORY

PLEASE LIST YOUR PAST MISSCARRIAGES OR TERMINATIONS IN ORDER….

YEAR WEEKS ? MISCARRIAGE/TERMINATION ? D AND C

PLEASE LIST YOUR PAST PREGNANCIES IN ORDER….

YEAR	SEX	NAME	WEEKS	WEIGHT	PREGNANCY/ ? PROBLEMS	DELIVERY MODE / PROBLEMS?

PATIENT HISTORY SHEET(OBS)

MEDICAL HISTORY

-PLEASE LIST YOUR PAST MEDICAL ILLNESSES CHECKLIST:

HEART/LUNGS
BLOOD PRESSURE
DIABETES
THYROID
HEPATITIS OR JAUNDICE
BLEEDING TENDENCY
BLADDER OR KIDNEY PROBLEMS
BOWELS
GENITAL HERPES OR OTHER INFECTIONS
DEPRESSION, ANXIETY OR OTHER PSYCHOLOGICAL CONDITIONS
INTRAVENOUS DRUG USE

-QUESTIONS-

HAVE YOU HAD ANY OPERATIONS?

HAVE YOU EVER HAD ANY ANAESTHETIC PROBLEMS?

HAVE TOU EVER HAD A BLOOD TRANSFUSION?

WHEN WAS YOUR LAST PAP SMEAR?……..….WAS IT NORMAL?…….

MEDICATIONS

PLEASE LIST YOUR CURRENT MEDICATIONS –
VITAMINS (e.g. ELEVIT, BLACKMORES GOLD, SWISS, VITAMIN D)

ALLERGIES

PLEASE LIST YOUR ALLERGIES

SOCIAL HISTORY

DO YOU SMOKE?……..IF SO HOW MANY PER DAY?…..……

WHAT IS YOUR OCCUPATION?

DO YOU DRINK MORE THEN 7 STANDARD DRINKS OF ALCOHOL PER WEEK?…….IF SO HOW MUCH?…….

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF DIABETES OR HIGH BLOOD PRESSURE

DO YOU OR YOUR FAMILY HAVE A HISTORY OF BREAST CANCER

DO YOU OR YOUR HUSBAND HAVE A HISTORY OF TWINS, BIRTH MALFORMATIONS OR ANY SERIOUS CONDITIONS THAT MAY RUN IN FAMILIES

(REVISED MAY2014)