

PATIENT DETAILS (confidential)

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:	
Email Address:		May we send SMS? Yes ☐ No ☐	
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?	Select from drop box
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 known 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: / /