

HISTORY FORM

Privacy: The information you complete below will only be used by the doctor in the treatment of your health and may be released to your GP and any hospital that you may need to be treated in.

1. Name: DOB:/...../..... Age:..... Last Period:/...../.....

Address: Email:

Phone: GP:

2. What is the main problem/pregnancy that you are seeing doctor about?

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3. How long has this been a problem?

4. What treatment have you had previously for this problem/pregnancy?

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5. How many children do you have, what are their ages, and were they normal deliveries?

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6. When was your last Pap smear and was it normal?

7. What medical conditions do you have?

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8. What gynaecological operations have you had, and in what year?

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9. What general operations have you had, and in what year?

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10. Please list the medications and dosages that you are currently taking:

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11. Please list any allergies: 12. Smoker ? Yes/No

13. Family History of Medical Problems/cancers:

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Office Use:/...../.....	O/E	Ix
D _ _ / N _		
Lks/wk _ _ _	Wt	Rx
P _ _ / _ _	Dx	H/O