

PATIENT MEDICAL HISTORY

Please complete and return this form prior to your first appointment



**Dr
Carin Black**

Patient's name	<input type="text"/>	Partner's name if applicable	<input type="text"/>
Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>	First appointment date	<input type="text"/>

Please tick if you are happy to receive information regarding pregnancy by SMS Email

Do you have any allergies? No Yes If yes, please specify details
e.g. medicine, adhesive tape, foods

Date of your last cervical screening test Result Normal Abnormal

Detail any treatment required

MEDICAL & SURGICAL HISTORY

Please specify any past medical issues you've had and the treatment required
e.g. asthma, heart disease, gastrointestinal problems, kidney disease, urinary tract infection, epilepsy,
thyroid disease, significant childhood illness.

PSYCHIATRIC HISTORY

Please specify any past psychiatric issues you've had and the treatment required
e.g. depression, anxiety, eating disorder, postnatal depression.

GYNAECOLOGICAL HISTORY

Please specify any past gynaecological issues and the treatment required
e.g. cervix abnormalities, fertility issues, investigations, polycystic ovary syndrome (PCO),
pelvic inflammatory disease (PID), Sexually Transmitted Infections (STIs).

FAMILY HISTORY

Please specify any family history of illness for you and your partner

e.g. diabetes (Type 1/Type2), thyroid disease, heart disease, stroke, blood pressure problems, congenital/genetic disorders, psychiatric illness, issues in pregnancy.

CURRENT MEDICATION

Please list any medications you are taking, including prescription, over-the-counter, vitamins, folate.

Do you smoke?

 No

 Yes

Amount per day

Do you drink alcohol?

 No

 Yes

Amount per week

Have you had a blood transfusion?

 No

 Yes

Year

Reason

How would you describe your diet?

e.g. vegetarian, vegan, healthy, unhealthy

Do you exercise?

 No

 Yes

If yes, what type and how often?

What is your height?

 cm

What was your pre pregnancy weight?

 kg

FOR NEW PATIENTS TO COMPLETE

PREVIOUS PREGNANCIES	PREGNANCY 1	PREGNANCY 2	PREGNANCY 3	PREGNANCY 4
Date of Birth				
Hospital				
Gestation (weeks)				
Outcome				
Labour				
Duration of labour				
Pain relief medication				
Birth type				
Baby weight				
Baby name				
Baby sex				
Feeding method				