Bayside Specialist Clinic

Shop 1 / 17 Waterloo Street Cleveland QLD 4163

Ph: 07 3483 1415 Fax: 07 3483 1422

Patient Personal Details

Mrs/Ms/Miss/Dr Surname____

Given Name______________________ Date of Birth______________________

Phone Home (__)____________________ Work(__)________________________

Mobile__________________ Email Address______________________________

Street Address____

_________________________________ Post Code _______________

Occupation ______________________________

Next of Kin/Partner ______________________ Relationship __________________

Contact No _________________________

HEALTHCARE COVER:

Medicare No: __ __ __ __ __ __ __ __ __ __ Ref No: ____ Expiry: _______ /__________

Pension No: __________________________ Expiry: _______ /__________

DVA No: ____________________________ Expiry: _______ / __________

Yes / No Do you have current Private Health Insurance Cover? Is your cover overseas Health Cover?

Health Fund: _________________________ Membership No: _______________

Yes / No Have you held your **Hospital** cover with your Private Health Fund for more than 12 months?

Yes / No Does your Private Health Fund Insurance cover you for **Obstetrics?**

Yes / No Does your Private Health Insurance cover you for Mental Health Services?

**** **If you are anticipating hospitalisation and / or surgery. Please check full details of your health cover with your Private Health Insurance Company** ****

PERSONAL MEDICAL HISTORY:

Please circle Yes or No if you have any of the following medical problems.

Heart Disease	**Yes**	**No**	Depression/Anxiety	**Yes**	**No**	Breast Problems	**Yes**	**No**
Diabetes	**Yes**	**No**	Anorexia/Bulimia	**Yes**	**No**	Urinary Tract Infection	**Yes**	**No**
Heart Murmurs	**Yes**	**No**	High Blood Pressure	**Yes**	**No**	Endometriosis	**Yes**	**No**
Kidney Disease	**Yes**	**No**	Asthma	**Yes**	**No**	Sexually Transmitted Disease	**Yes**	**No**
Seizures	**Yes**	**No**	Hepatitis	**Yes**	**No**	History of Ectopic Pregnancy	**Yes**	**No**
Skin Disorders	**Yes**	**No**	Arthritis	**Yes**	**No**	Uterine Fibroids	**Yes**	**No**
Intestinal Problems	**Yes**	**No**	Cancer	**Yes**	**No**	Thyroid Disease	**Yes**	**No**
High Cholesterol	**Yes**	**No**	Tuberculosis	**Yes**	**No**	Osteoporosis	**Yes**	**No**
Jaundice (yellowing Of the skin)	**Yes**	**No**	Migraines	**Yes**	**No**	Blood Transfusions	**Yes**	**No**
DVT (Blood Clots)	**Yes**	**No**	Anaemia/Blood Disease	**Yes**	**No**	Jehovah Witness	**Yes**	**No**
Vision or Hearing Impairment	**Yes**	**No**	Mitral Valve Prolapse	**Yes**	**No**			

FAMILY HISTORY: Please place a tick in the box of the blood related relatives that have the following.

CONDITION	MOTHER	FATHER	BROTHER	SISTER	GRANDPARENTS
Diabetes					
Heart Disease					
High Blood Pressure					
DVT (Blood Clots)					
Cancer					

CURRENT MEDICATIONS: Please list all <u>Medications & Dosage</u> you are currently taking.

____

____

____

ALLERGIES: Please list all <u>Medications</u> from which you have had an allergic reaction.

____

____

PREVIOUS SURGERY

Year	Surgery	Year	Surgery

GYNAECOLOGICAL HISTORY:

1. Menstrual History:

(a) How old were you when your periods first started? ____

(b) How many days apart are your periods? ____

(c) How many days does your period last? ____

(d) Do you have cramping or pain? ____

(e) Is your flow light, medium, heavy? ____

(f) Are you currently having problems with your period? ____

2. Pap Smear History:

(a) When was your last pap smear? ____

(b) Was it normal? ____

(c) Have you ever had an abnormal pap smear? ____

(d) If **YES**, what was done? ____

3. Breast History

(a) Have you ever had any breast problems? ____

(b) When was your last mammogram? ____

(c) Have you ever had an abnormal mammogram? ____

OBSTETRICAL HISTORY:

How many times have you been pregnant? ___________ How many children do you have? ____________

Month&Year Of birth	Gestational Age	Labour	Delivery Type	Weight	Sex	Name	Remarks

SOCIAL HISTORY:

Marital Status: Single Married Widow Divorced De Facto

Partners Name _________________________ Partners DOB _______________ Vasectomy: **Yes** or **No**

Partners Occupation _______________________________

Do you smoke? **Yes** or **No** How many per day? ____

How much Alcohol do you consume per day? ____

Are you currently sexually active? ____

Are you currently using any type of birth control? ____

Consent & Release Of Medical Information

I give consent to Bayside Obstetrics & Gynaecology to contact any of my previous medical practitioners or hospitals to obtain previous health records that are relevant to my current care.

I authorise those previous practitioners and hospitals to release such information, even sensitive health records, to Bayside Specialist Clinic as requested.

How did you hear about us? □ GP referral □ Website/Google □ Cinema Advert □ Facebook □ Referred by a friend

I understand that during my consultation it may be necessary for minor procedures to be performed and I consent to those procedures being carried out after suitable consultation with myself.

Patient Signature____ Date ____/____/________