Patient Medical Sheet - Pregnancy

Patient: First Name: _____ Last Name: _____

Partner: First Name: _____ Last Name: _____

Current Pregnancy

First Day of Last Period: _____ Was your cycle: ☐ Regular ☐ Irregular

Was Conception: Spontaneous ☐ Ovulation Drugs ☐ IVF ☐

Estimated Due Date: _____

Have you had any Ultrasounds done relating to this pregnancy Yes ☐ No ☐

If Yes, where were the ultrasounds perrformed ? ☐ NCDI ☐ Canberra Imaging

How many Ultrasounds have you had during this pregnancy? ☐ < 12 weeks ☐ > 12 weeks

Have you had any blood tests done relating to this pregnancy? Yes ☐ No ☐

If Yes, where were the blood tests perrformed ? ☐ Capital Path ☐ ACT Pathology ☐ Laverty ☐ Other

Have you had any bleeding? No ☐ Yes ☐

Do you Smoke? No ☐ Yes ☐ ☐ per day

Do you drink alcohol when you are not pregnant? No ☐ Yes ☐ ☐ per day/week/month

History

Menarch (Age at first period) ☐ Last PAP Smear: ☐ Result: ☐

Any Abnormal PAP Smears in the past? No ☐ Yes ☐ (please specify) _____

How Many Pregnancies have you had? ☐ No. delivered at term ☐ Miscarriages ☐

Delivered before 37 weeks ☐ Terminations ☐

Medical Problems

Diabetes: Yes ☐ No ☐ Details _____

Hypertension: Yes ☐ No ☐ Details _____

Epilepsy: Yes ☐ No ☐ Details _____

Other: _____

Any significant Family History: _____

_____

Do you wish to know the sex of this baby if it can be determined? Yes ☐ No ☐

Do you have any particular concerns which you would like addressed at today's visit? _____

_____

_____