

## 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 performed?  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 performed?  Capital Path  ACT Pathology  Lavery  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? \_\_\_\_\_