Patient Medical Sheet - Pregnancy

Patient: First Name: _____ Last Name: _____

Partner: First Name: _____ Last Name: _____

Current Pregnancy

First Day of Last Period: _____ Is your cycle usually: 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 they done: _____

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 use recreational drugs? No ☐ Yes ☐ ☐ per day

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

History

Last PAP Smear/CST date: _____ Result: _____

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

How many pregnancies have you had? ☐ Delivered at or after full term ☐ Miscarriages ☐
(including the current pregnancy) *(37+ weeks)*

Delivered before 37 weeks ☐ Terminations ☐

Surgical history: _____

Medical Problems

Diabetes: Yes ☐ No ☐ Details _____

Thyroid: Yes ☐ No ☐ Details _____

Hypertension: Yes ☐ No ☐ Details _____

Epilepsy: Yes ☐ No ☐ Details _____

Asthma: Yes ☐ No ☐ Details _____

Current medications: Yes ☐ No ☐ Details _____

Allergies Yes ☐ No ☐ Details _____

Anxiety/Depression 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? _____