Mildura O&G

MBBS, FRANZCOG

192 Ontario Ave
Mildura VIC 3502

Tel: 03 5021 4404
Fax: 03 5021 4405

www.milduraoandg.com.au

New Mid Medical History

At Mildura O&G we aim to provide you and your baby with a high level of medical and midwifery care to ensure the best pregnancy outcome possible. A detailed knowledge of your health and past history is required to enable this. Please fill out the following form and bring it to your first appointment for further discussion. If you have any other concerns or questions please raise them with your Midwife and/or Obstetrician at your first visit.

Your current & any previous pregnancies will be also discussed at your first appointment.

NAME: ____________________________________ DATE OF BIRTH:________________

Medical History

- Do you have asthma? Yes/No
- Do you have diabetes? Yes/No
- Do you have epilepsy? Yes/No
- Do you have high blood pressure? Yes/No
- Do you have high cholesterol? Yes/No
- Have you ever been told you have "Lupus"/SLE? Yes/No
- Have you ever had a Deep Vein Thrombosis or Pulmonary Embolism? Yes/No
- Do you have anaemia/low red blood cells? Yes/No
- Do you get more than 2 bladder infections per year? Yes/No
- Do you have Vitamin D deficiency? Yes/No

Do you have any illnesses that affect the following body systems that were not listed above?

- Respiratory/Lung? ____
- Cardiac/Heart?____
- Gastrointestinal/Stomach/Bowel?____
- Endocrine/Thyroid?____
- Neurological/Brain/Nerves?____
- Renal/Kidneys?____
- Haematological/Blood?____
- Rheumatological/Joints?____
- Chronic Pain?____
- Infectious Illness?____
- Congential/Genetic?____

Have you ever received an organ transplant? Yes/No

Surgical History

Have you ever had a surgery? Yes/No

If yes, were there any anaesthetic complications?________________________________

If yes, what surgeries have you had?

____
____
____
____

If you have another medical/surgical problem we have not addressed, please describe below:

____
____
____

Gynaecological History

Prior to pregnancy how often did you have a period?_______

When was your last PAP Smear?__________

Have you ever had an abnormal PAP Smear? Yes/No

Have you ever had a sexually transmitted infection such as:

Chlamydia? Yes/No Gonorrhoea? Yes/No

Herpes? Yes/No Syphilis? Yes/No

Has anyone ever told you that you may have damage to your fallopian tubes? Yes/No

Mental Health

Have you ever been diganosed with a mental health problem such as:

Depression? Yes/No Anxiety? Yes/No

Bipolar Disorder? Yes/No Schizophrenia? Yes/No

Other:____

Medication History

Are you taking folic acid supplementation? Yes/No

Are you taking iodine supplementation? Yes/No

Please list your medications including over the counter / vitamins / herbs / natural remedies:

____

____

____

____

____

____

Please list any allergies you have:____

____

Social History:

Occupation: ____

Who lives with you at home?____

Are you Vegetarian / Vegan? Yes/No

Are you a smoker? Yes/No If yes, how many per day:_________

Did you drink alcohol prior to pregnancy? Yes/No If yes, how many per week:________

Are you still drinking alcohol during pregnancy? Yes/No If yes, how many per week:________

Do you use any reactional drugs? Yes/No

When was your last Whooping Cough (Pertussis) vaccination? ________

When was your last Flu Vaccination? ________

Family History

Do any of your immediate family have any medical illnesses?

Mother:____

Father:____

Sisters/Brothers:____

Your other children:____

Is there any other family medical history you are aware of, particularly genetic problems or problems a family member may have been born with? ____

____

Partner Details

Occupation:____

Does your partner smoke? Yes/No

When was your partner's last Whooping Cough (Pertussis) Vaccination?________

Does you partner or any of his family have any genetic problems or problems they were born with? Yes/No