Please fill in **all details clearly*

Patient Contact Details		
Title:	First name:	Surname:
Preferred name:		Maiden name (if applicable):
Date of birth: / /	Daytime contact phone number:	
Email address:		
Residential address:		
Suburb:		Postcode:

Occupation:	Religion *(optional)* :	
Country of birth:	☐ Aboriginal	☐ Torres Strait Islander
Language/s spoken:		

Emergency Contact Information			
Title:	First name:	Surname:	
Contact number:		Relationship:	Next of kin: Y / N

Fertility Patients Only			
Title:	First name:	Surname:	Date of birth:
Contact number:		Relationship:	

Medicare													
Medicare #:												Ref # :	Expiry: /

Private Health Insurance - HOSPITAL COVER ONLY		
Health fund provider:	Membership # :	Ref:
Name on card:		

Concessions (if applicable)	
Healthcare/Pensioner card # :	Expiry:

Referral	
Referring doctor:	GP clinic:
Is this your usual doctor? Y / N	If NO, name of usual GP:

How did you hear about us?	☐ GP	☐ Word of mouth	☐ Internet	☐ Other:

Do you CONSENT to be notified of test results via email?	☐ YES	☐ NO

Why have you come to see Dr Thompson?

Have you had *any* previous surgeries/procedures?	

Current medications		Allergy	Reaction to allergy

Height (cm):	Date of last pap smear:	Result:
Weight (kgs):	Date of last mammogram:	Result:

How often do you get your period?		Please circle any concerns with your period below					
Vomiting	Migraines	Heavy	Frequent	Clots	Flooding	Pelvic Pain	Back Pain

Are you sexually active?	Y / N	Please circle any concerns with sexual activity below	
Pain	Bleeding with sexual activity	Low libido	Other:

Have you ever contracted any STIs?	Y / N	If yes, when?	

Have you ever had difficulty conceiving?	Y / N

Have you ever been pregnant?	Y / N	Please circle the outcome(s) below			
Ectopic	Miscarriage	Termination	Vaginal delivery	Caesarean Section	VTOP

Have you ever used hormonal treatments?	Y / N	If yes, please circle which treatments used below					
The Pill	Mirena IUD	Copper IUD	Implanon	Nuva Ring	Depo Provera	HRT	Other:

Do you have concerns with your bladder?	Y / N	Please circle any concerns with your bladder below	
UTI	Incomplete emptying	Incontinence	Other:

Do you have concerns with your bowel?	Y / N	Please circle any concerns with your bowel below			
Constipation	Diarrhoea	IBS	Pain	Chron's/Ulcerative Colitis	Other:

Do you have any concerns with your vulva?	Y / N	Please circle any concerns with your vulva below		
Itching	Discharge	Thrush	Scarring	Other:

Do you have any concerns with your uterus?	Y / N	Please circle any concerns with your uterus below	
Fibroids	Polyps	Thick lining	Other:

Do you have any concerns with your cervix?	Y / N	Please circle any concerns with your cervix below	
Polyp	Pap smear result	Other:	

How often do you exercise?		Do you have any food restrictions?	

Not very	On a scale of 1 - 10, what is your current stress level?								*Very*
1	2	3	4	5	6	7	8	9	10
What are your current stressors?									

Do you smoke / vape?	Y / N	If yes, how often?	
Do you drink alcohol?	Y / N	If yes, how often?	
Do you take recreational drugs?	Y / N	If yes, how often?	