Name: _____ **DOB:** _____ Date of appt: _____

MEDICAL HISTORY

Are you currently required to self-isolate under NSW Health guidelines?	Yes No
Have you had a COVID test during the last 2 weeks?	Yes No
If yes, why?	
Do you currently have ANY cold/flu symptoms?	Yes No
If yes, what symptoms?	
Have you been fully vaccinated against COVID-19?	Yes No
Have you ever had any of the following conditions?	
Heart murmur	Yes No
Any heart or lung problem	Yes No
High blood pressure	Yes No
Low blood pressure	Yes No
Asthma	Yes No
If yes, when did you last take anything for it?	
Epilepsy	Yes No
Diabetes	Yes No
If yes, is it treated with diet only / oral medication / insulin injection	Yes No
Bleeding tendencies	Yes No
Blood clots / DVT / Thrombosis	Yes No
HIV	Yes No
Hepatitis A	Yes No
Hepatitis B	Yes No
Hepatitis C	Yes No
Have you been treated for any other medical condition?	Yes No
Please provide details.	
What is your blood group? (if known)	
Are you currently breast feeding?	Yes No
Do you have any dentures or oral piercings?	Yes No

MEDICATIONS

Do you take medication?	Yes No
If yes, what is it called?	
For what condition is this medication taken?	
How often do you take it?	
When was it last taken?	

ALLERGIES

Do you have any allergies? *e.g. penicillin, antibiotics, aspirin, soy products, egg, latex, plasters*	Yes No Cont …
Band-Aids), antiseptics or anything else?	
Allergy details	

DO YOU SMOKE?	Yes No
If yes, how many cigarettes per day?	
On average, how many alcoholic drinks per week?	
Do you use recreational drugs?	Yes No
Have you ever used IV drugs?	Yes No

PREVIOUS SEDATION / GENERAL ANAESTHETIC

Have you ever had an anaesthetic where you were sedated or fully asleep?	Yes No
What was the operation / procedure for?	
Have you, or a blood relative, ever had any problems with an anaesthetic?	Yes No
If yes, please provide details.	

FASTING (for surgical procedures only)

When did you last eat any food or drink anything other than water?	
When did you last drink water?	

MENSTRUAL HISTORY

When was the first day of your last period? (dd/mm/yy)	☐ (Tick if unsure)
How often do you get a period? (less than 28 days, approx. 28 days, more than 28, or irregular?)	
How many days do you usually bleed?	
How would you describe your normal amount of bleeding?	
How would you describe the level of pain that you normally experience during a period?	

GYNAECOLOGICAL TREATMENT

Have you ever had any treatment to your cervix, including Cone Biopsy, Lletz procedure, Laser or Diathermy, or any other gynaecological surgery?	Yes No
If yes, please provide details:	
Have you ever had an ectopic pregnancy (in the fallopian tube)?	Yes No
If YES, what happened?	

If you are unsure of any of these questions, please ask the doctor during your consultation.

To the best of my knowledge, the answers to the above questions are correct.

Signed: .....

Sign at the clinic

When completed, save PDF and email to reception@privteclinic.com.au or print and bring to your appointment.