PATIENT HISTORY SHEET **Height**: **Weight**:
Name: **DOB**:

Past medical History – (for example diabetes, blood pressure, asthma, depression)

Past surgical history – (for example tonsils, appendix, wisdom teeth)

Any problems with general anaesthetic?
Any **allergies** to any medicines etc?
What reaction did you have?
First day of last normal menstrual period?
How many **children** have you had? How were they born?
Vaginal birth
Caesarean section
Have you had any:
Miscarriages? If so how many? Curette needed?
Terminations of pregnancy? If so, how many?

Have you got a regular **sexual partner**?
What year did you and he/she partner first get together?
Are you using contraception? If so, what are you using?
If no regular sexual partner, how many sexual partners in the last 12 months?
Did you use condoms?
When was your last STI screen?

What do you do for **work/study/retired**?
Family History – if so, please indicate who is affected? (If no history, then please write “nil” don’t just leave blank)
Gynae cancers (ovary, uterus, cervix) ?
Breast cancers ?
Clots in the legs or clots in the lungs?
Bowel cancer?

Are you a **smoker**? If so, regularly or intermittently? How many a day?
If you are an ex-smoker, when did you stop?
Do you drink **alcohol**? How many on average a week?
Please list your **medications and the dosage** that you take **REGULARLY**.
Please include vitamins and/or supplements.

When was your last **Pap smear**? Was it normal?
When was your last **mammogram**, if you have them? Was it normal?

DATE: Signed: