# DR EVELYN CHIA

OBSTETRICIAN & GYNAECOLOGIST

## PATIENT INFORMATION
**(Please print)**

**TITLE** **MS / MISS / MRS / DR / PROF**

**SURNAME (**as on Medicare**)** _____

**PREFERRED NAME** _____

**OTHER NAME/S** _____

**D.O.B** _____

**ADDRESS** _____

_____

**TELEPHONE** **Home** _____ **Work** _____

**Mobile** _____ **Other** _____

**E-MAIL:** _____

**OCCUPATION:** _____

**EMERGENCY CONTACT** _____

**CONTACT NUMBER** _____ **2ND NUMBER** _____

**RELATIONSHIP TO PATIENT** _____

**MEDICARE No.** __ __ __ __ __ __ __ __ __ __

**Number against your name:** ____ **Expiry** ____ / ____

**HEALTH FUND** _____

**MEMBER No:** _____

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## HEALTH QUESTIONAIRE

**DATE COMPLETED: _____**

**FULL NAME** _____

**DATE OF BIRTH** _____

**COUNTRY OF BIRTH** _____

**OCCUPATION** _____ **F/T___ OR P/T ___**

**OBSTETRIC HISTORY:**

| | | |
|---|---|---|
| Have you ever delivered a vaginally? | Yes / No | If yes, how many? _____ |
| Have you ever had a caesarean section? | Yes / No | If yes, how many? _____ |
| Have you ever had a miscarriage? | Yes / No | If yes, how many? _____ |
| Have you ever had an ectopic pregnancy? | Yes / No | If yes, how many? _____ |
| Have you had an abortion? | Yes / No | If yes, how many? _____ |

Any other relevant obstetric history or complications:

_____

_____

_____

**SCREENING TESTS:**

| | | |
|---|---|---|
| Last pap smear | Date: _____ | Normal / Abnormal |
| Ever had an abnormal pap smear? | Date: _____ | Did you require treatment? Yes / No |
| Last mammogram | Date: _____ | Normal / Abnormal |
| Ever had an abnormal mammogram? | Date: _____ | Did you require treatment? Yes / No |
| Last bone density | Date: _____ | Normal / Abnormal |
| Ever had an abnormal bone density? | Date: _____ | Did you require treatment? Yes / No |

**GYNAECOLOGY HISTORY:**

Do you have a gynaecological history? Yes / No

If yes, please specify:

_____

_____

_____

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**OPERATIONS:**

Have you previously had any operations? Please include age at the time of operation and if any complications

_____

_____

_____

**ANAESTHETICS:**

Have you had a general anaesthetic before? Yes / No

Have you had a local anaesthetic before? Yes / No

Have you had an epidural or spinal before? Yes / No

Did you have any problems with any of the above? Yes / No

If yes, please specify

_____

_____

_____

**ALLERGIES:**

Drug (e.g. Penicillin): _____

Food: _____

Other: _____

**MEDICATIONS:**

Are you currently on any regular medications? Yes / No
If yes, please specify

_____

_____

_____

Name of drug: _____ Strength: _____ How often per day: _____

Name of drug: _____ Strength: _____ How often per day: _____

Name of drug: _____ Strength: _____ How often per day: _____

**OTHER CURRENT INTAKE:**

Cigarettes Yes / No If yes, how many per day/week? _____

Alcohol Yes / No If yes, how many per day/week? _____

Recreational drugs Yes / No If yes, how many per day/week? _____

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## HEALTH QUESTIONAIRE –cont.

### MEDICAL CONDITIONS:

Please answer yes or no if you have ever had any of the below:

| | | | |
|---|---|---|---|
| Heart Attack | Yes / No | Heart problems | Yes / No |
| Rheumatic Fever | Yes / No | High Blood Pressure | Yes / No |
| High Cholesterol | Yes / No | Stroke | Yes / No |
| Thyroid problems | Yes / No | Migraines | Yes / No |
| Anxiety | Yes / No | Depression | Yes / No |
| Gastric reflux | Yes / No | Ulcers (Gastric etc) | Yes / No |
| Irritable bowel | Yes / No | Back pain | Yes / No |
| Arthritis | Yes / No | Epilepsy/Fits | Yes / No |
| Asthma | Yes / No | Diabetes | Yes / No |
| Anaemia | Yes / No | Bleeding/Bruising | Yes / No |
| Deep Vein Thrombosis | Yes / No | Varicose Veins | Yes / No |
| Pulmonary Embolus | Yes / No | Recurrent Candida/Thrush | Yes / No |
| Chlamydia | Yes / No | Pelvic Inflammatory Disease | Yes / No |
| Herpes | Yes / No | Hep A, B, C, HIV Aids | Yes / No |

Do you have any other medical conditions? Yes / No

If yes, please specify:

_____

_____

_____

**Relevant Family History:**

Please list any family members with significant medical history including cancer
(e.g. Mother's sister – alive – 40yo –breast, bowel or ovarian cancer)

| | | | |
|---|---|---|---|
| Mother | Alive / Deceased | Age: _____ | Health Problems: _____ |
| Father | Alive / Deceased | Age: _____ | Health Problems: _____ |
| _____ | Alive / Deceased | Age: _____ | Health Problems: _____ |
| _____ | Alive / Deceased | Age: _____ | Health Problems: _____ |

The information I have given is correct and complete to the best of my knowledge.

Signature of patient: _____ Date: _____

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- I understand that Dr Chia takes a full medical history that relates to my medical condition and management.
- I agree that relevant information may be obtained from other medical practitioners, such as GP's and specialists, other health care providers, pathologist, hospital and Day Surgery Units as necessary.
- I agree that Dr Chia may discuss my medical history, diagnosis and management with my general practitioner and other relevant Medical Specialists in relation to my medical management.
- I understand that I may apply to access my health records.
- I understand that I am responsible for my account to be paid by the due date and any unpaid accounts that require follow up outside of the practice, will acquire a 30% Collection fee in addition to any legal costs incurred.

Patients Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Witness Name: _____