Gynaecology First Visit

Date.................... Last name.................... First name....................

Number.................... DOB.................... Age....................

Previous medical history

- ☐ Migraine
- ☐ Liver disease
- ☐ Thrombosis
- ☐ Epilepsy
- ☐ Breast disease
- ☐ Hypertension
- ☐ Varicose veins
- ☐ Diabetes
- ☐ Other

Family history

- ☐ MIICVA
- ☐ OM
- ☐ Bp
- ☐ VTE

Antiretrovirals

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Other drugs

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....

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Smoking ☐ current........../day ☐ ex-smoker ☐ never

Allergies....................

Pregnancy history

Date	Outcome / mode of delivery and status of child
....	....
....	....
....	....
....	....

Future pregnancy plans: ☐ Yes ☐ No

Sexual History: Current partner? ☐ Yes ☐ No …is: ☐ HIV positive ☐ negative ☐ don't know

Contraception: ☐ Not sexually active ☐ None - sexually active ☐ Condoms ☐ Diaphragm ☐ COC ☐ POP ☐ Depo (Last injection?) ☐ IUD ☐ IUS (When inserted?)

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Past STI/PID:....................

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Smear History: Date of last smear .... ☐ NAD ☐ Abn

Previous treatment ☐ Yes ☐ No What, what for and when ....

Menstrual history

Cycle: ☐ regular cycle ☐ irregular cycle LMP ....

☐ IMB

☐ Abnormal Discharge

☐ Dysmenorrhoea

☐ PMS

☐ PCB

☐ Menorrhagia

☐ Pelvic pain

☐ Perimenopausal

Gynae adm/OPD

Other

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