Long Distance Patient Questionnaire

P: (07) 3332 1999 F:(07) 3332 1990 www.evehealth.com.au

Thank you for completing this questionnaire prior to your appointment at our clinic. This Questionnaire should be mailed or faxed to our office prior to your appointment. Please bring all relevant information, including any letters, test results, ultrasound scans or X-Rays to your appointment.

Date: ________________ Name: ____ Date of Birth: ________________

Referring Doctor: ____

Please ensure that the referring letter is attached or has been received by our office prior to forwarding this application.

MENSTRUAL CYCLE

How old were you when you first got your periods? ________________________

Is your cycle regular? ☐ Yes ☐ No

If your cycle is regular:

How many days do you normally menstruate (bleed)? ______________________

How long is your cycle normally? ____
(how many days from the day of your menstruation to the start of the next)

Do you have pain with your period? ☐ Yes ☐ No

Do you know when you ovulate? ☐ Yes ☐ No

Are you aware of vaginal mucus changes? ☐ Yes ☐ No

PREVIOUS PREGNANCIES

If you have had any previous pregnancies, please complete the following table:

DATE	PARTNER	LIVE(Y/N)	M/A/E	WKS	DELIVERY	SEX	WT	COMP

M/A/E = Miscarriage/ Abortion/ Ectopic Wt = Weight (kg) Comp =Complication or Comments

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MEDICAL HISTORY

Have you been diagnosed with any of the following?

- ☐ Cancer
- ☐ Clots in the legs or lungs
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Endometriosis
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Hereditary Condition
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Polycystic Ovarian Disease
- ☐ Sexually Transmitted Infection
- ☐ Thyroid Problems
- ☐ Thalassemia

If you selected any of the above, please provide details (Please put details on separate piece of paper if required):

____

____

____

Date of your last Pap Smear: ______________________________

Have you ever had an abnormal Pap Smear? ☐ Yes ☐ No

SURGICAL HISTORY

DATE	INSTITUTION	PROCEDURE/FINDINGS

CURRENT MEDICATIONS

Do you take any regular medicine? ☐ Yes ☐ No Details: ______________________________

Do you have any allergies? ☐ Yes ☐ No Details: ______________________________

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LIFESTYLE

Occupation: ______________________________

Do you drink alcohol? ☐ Yes ☐ No How much? ____________________

Do you smoke tobacco (cigarettes)? ☐ Yes ☐ No How much? ____________________

Do you use other illicit drugs? ☐ Yes ☐ No How much? ____________________

FAMILY HISTORY

☐ Cancer
☐ Clots in the legs or lungs
☐ Cystic Fibrosis
☐ Diabetes
☐ Endometriosis
☐ Epilepsy
☐ Heart Disease
☐ Hereditary Condition
☐ High Blood Pressure
☐ Kidney Disease
☐ Polycystic Ovarian Disease
☐ Sexually Transmitted Infection
☐ Thyroid Problems
☐ Thalassemia

MEDICAL DETAILS

These details have to be supplied to assess your suitability for a general anaesthetic.

Height: ____________________ Weight: ____________________ Blood Pressure: ____________________

Please do not hesitate to contact our office at any point for further information on (07) 33321999.