Dr Sarah Woodbury
Obstetrician

Health Questionnaire
CONFIDENTIAL

Full Name					
Date of birth					
Occupation					
Partners name					
Occupation					
Your height	cms		Pre-pregnancy weight	kgs	
LMP (first day of last period)			Usual cycle length	days	
Cycle	Do you usually have a regular / irregular cycle				

OBSTETRIC HISTORY

Previous pregnancies	No	Yes	1	2	3
Babies names					
Outcome: Mode of birth					
Gestation: weeks					
Hospital					

What type of birth did you have: LSCS/ vaginal birth/ instrumental birth/ epidural block. Did you have any pregnancy related medical issues, (eg gestational diabetes, high blood pressure, pre-eclampsia)?

BREASTFEEDING

Did you have difficulty establishing breast feeding?	Yes	No	Not applicable
How long did you breast feed for?			

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QUALITY OF CARE

How do you think the care and management of your previous pregnancy could be improved?

SCREENING TESTS

When was your last CST (pap smear)?			
Have you ever had an abnormal pap smear?	Year	Yes	No
Have you ever been diagnosed with genital herpes?		Yes	No

MEDICAL and / or MENTAL HEALTH CONDITIONS

Do you have any medical or mental health conditions?	Yes	No
If yes, please specify:		

CURRENT INTAKE

Cigarettes	Yes	No	If yes, how many per day?	
Alcohol	Yes	No	If yes, how many per day / week?	
Recreational drugs	Yes	No	If yes, what type?	

ALLERGIES

Drug or allergen (eg Penicillin)	
Reaction (eg rash, vomiting, anaphylactic reaction)	

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RELEVANT FAMILY HISTORY

Please list any family members with a significant medical history, including cancer etc

	Deceased	Alive	Age	Health problems
EXAMPLE *Mother's sister*		*alive*	*40yo*	*breast, bowel or ovarian cancer*
Mother				
Father				

How did you hear about us?	

I have read all questions and the information I have given is correct and complete to the best of my knowledge

Signature of patient				
Date				
Name of patient				

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