Women CENTRE

Western Australia
Oncology
Menopause
Endometriosis
New Mothers

# PATIENT HISTORY

NAME ________________________________ DOB_____/_______/______

REASON FOR REFERRAL ________________________________

PREGNANCIES ________________________________OUTCOME ________________

SMOKING ______________CIGARETTES/DAY ALCOHOL ________________STD DRINKS/DAY

CURRENT AND PRIOR ILLNESSES/MEDICAL CONDITIONS

________________________________

________________________________

________________________________

________________________________

________________________________

PREVIOUS OPERATIONS/SURGERY

________________________________

________________________________

________________________________

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ALLERGIES/REACTIONS ________________________________

SOCIAL HISTORY ________________________________

| CURRENT MEDICATIONS | DOSAGE | CURRENT MEDICATIONS | DOSAGE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

1. Please note that the information supplied is confidential and patient privacy is always maintained.
2. I declare that all information written on the above form is true to the best of my knowledge.
3. Images may be captured and stored on your medical records during clinical examination and/or colposcopy examination to aide in documentation and treatment progress of clinical problems.
4. All images are de-identified. Should you not wish any images to be captured, please inform us.
5. Medical students may be present during examinations, if you do not wish this, please inform your doctor.
6. I consent for my medical information to be forwarded to other health professionals if necessary.

Sign ________________________________Date _______/_______/________