Hampton Park
Women's Health Care

4 Warana Drive, Hampton Park, Victoria 3976
Ph. (03) 97992817
www.hpwh.com.au

PATIENT ADMISSION DETAILS
QF 01-02

PLEASE PRINT AND BRING WITH YOU

First Name		**MEDICAL HISTORY**	**Y**	**N**	**Comments**
Surname		Allergies			
Appointment time		Breast Feeding			
D.O.B		History of Irregular Heart rhythm			
House Number		Pneumonia/ Asthma/ Recent chest infection			
Suburb		Diabetes/ Endocrine problems			
Postcode		Gastro-oesophageal reflux (GORD)			
STATE		Bleeding or clotting disorder/ bruising			
Preferred Ph No		Hepatitis A, B or C/ HIV			
Email Address		Migraines			
Married?		History of DVT (Deep vein thrombosis) or clots			
Defacto?		Depression/ Anxiety/Psychiatric illness			
Smoker?		Back, mobility or joint problems			
Aboriginal Decent?		Epilepsy or seizures			
Did this Doctor refer us to you?		History of 2 of more falls in the past 12 months			
Doctors Name		Do you have a treatment limiting order (such as refusal of blood products)?			
Doctors Address		History of any gynaecological problems (PCOS, cysts, fibroids, pelvic infections)			
Medicare No		Any problems with anaesthetic in the past			

Position on card	
Expiry Date	
Health Care Card No	
Expiry Date	
Private Health Fund?	
Member No	
Expiry Date	
Excess?	
Co-Payment?	
How did you hear about us?	

Office Use only

- Non Medicare
- I.D Sighted and copied?
- Blood group card copied?
- Signed & Dated____________________________

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Gynaecological History	
First Day of Last Normal Menstrual Period	
Blood Group	
Current Weight	
Height	
Are you taking any Medications at the moment?	
What are you taking? Y/N	
What time did you have anything to eat and drink?	
What was it?	
Were you using any contraception	
What type?	
Any previous contraception tried before? Y/N	
The pill	
Depo	
Implanon	
IUD – Mirena/Copper	
Any concerns with these? Y/N	
How many times have you been pregnant?	
Any issues with pregnancy? Y/N	
Number of Normal Vaginal Delivery's? Caesarean_____ Termination_____ Miscarriage_____ Ectopic_____	
Do you feel confident in your decision to terminate This pregnancy? Y/N	
Do you require a medical Certificate? Y/N	
Does your carer require a carer's Certificate? Y/N	
We are able to provide you with a referral to a counselling service. Do you want this? Y/N	

Why do you wish to terminate this pregnancy?	**Y**	**N**
Financial		
Emotionally couldn't cope		
I feel unable to cope physically		
I am concerned about my health during pregnancy		
I am concerned about the effect of having another child on my family		
I am concerned about an abnormal baby		
Family complete		
Studying		
Single mother		
Lack of support		
My partner and I have separated		
Medical problems		
Too young		
Concerned about being too old		
Unplanned – Please provide information		

Patient Signature:		Dated:	