Dr Meera Mani FRANZCOG, DDU
Consultant Obstetrician and Gynaecologist
Provider No:6089872A
Ph 02 8456 4363 Fax: 02 8914 6739

Hornsby Women's Health
Suite 115, The Parkway SAN Clinic
172 Fox Valley Road
Wahroonga, NSW 2076

Personal Details

Title (please circle which applies): Mr./Mrs./Ms./Miss./Prof./Dr./Sis/Rev

Family Name: _____ Given Name: _____

Address: _____

_____ Postcode: _____

Date of Birth: _____

Home Phone Number: _____ Work Phone Number: _____

Mobile Phone Number: _____ Email Address: _____

Emergency Contact

Name: _____ Relationship: _____ Phone number: _____

Do you give us permission to contact this person in the event of an emergency or if we are unable to contact you? Yes / No

Account Details

Medicare Number: _____ Reference (number in front of your name): ___

Expiry Date: _____

Pension / Health Care Card Number: _____

Veterans Affairs Number: _____

Private Health Fund: _____ Membership Number: _____

Referring Doctor: _____

Address: _____

GP Name/Address: _____

Consent

I hereby give my consent for the release of necessary medical documentation being requested by Dr Meera Mani (Hornsby Women's Health) from hospital departments or ancillary practices such as pathology, X-ray departments etc. I also give my consent for procedures such as Ultrasound, Colposcopy, Biopsies as deemed necessary.

We comply with Australian Privacy Act – for more information please to http://www.privacy.gov.au

Signed: _____ Date**:** _____

New Patient Details (History) – Please Print **(**Stick label here)

Name: ……..Partner's Name……
Age :…….

Reason for referral/Problems

1 …….
2 …….
3 …….
4 …….
5 …….

Menstrual History – Please circle

Are your periods Regular or irregular?
Painful or Painless?
Light or Moderate or Heavy?
Do you pass clots? Y…N
How often is you period – Once every ……. days, lasting for……days
Have you noticed spotting between periods? Y…. N
Have you noticed bleeding after intercourse? Y…. N
If you are menopausal, have you noticed any unusual bleeding? Y…. N
Do you have any Premenstrual symptoms?

Obstetric history

Is there a history of Infertility?.....Y……N
Have you had any Miscarriages or Terminations of pregnancy? .....Y……N
How many Deliveries or Child Births have you had?
Please list details of all pregnancies regardless of the outcome including, Details of Deliveries i.e., Normal or Caesarean, Full term or preterm, any complications with pregnancy or birth?

Serial No & Yr.	Mode of birth	Gestation @ birth	Birthweight and sex	Problems in pregnancy &birth

Contraceptive History

What method of contraception do you use for family planning?.....

What methods of contraception have you used in the past? Please provide details below -

Name/Method	Duration	Problems

Menopausal Symptoms

Have you had any menopausal symptoms? Yes ----------No----------Not applicable

Vaginal dryness
Hot flushes
Insomnia
Drenching night sweats

Pap Smears or Cervical Screening test

	Yes	No	Date/Result
Up to date?			
Any abnormal			
Genital warts			
Genital herpes			
Cervix treatment			
Cervical cancer Vaccination			

Sexual history

	Yes	No	Details
Sexually Active			
Pain With sex			
Bleeding after Sex			

Pelvic pain

	Yes	No	Details
Chronic Pelvic pain			
Pelvic Infection			
Pelvic Abscess			
H/O Endometriosis			
H/O Polycystic Ovary			
Vaginal Discharge			

Past medical history

Disorder	Yes	No	Details and Treating Specialist
Heart Disease			
High Blood Pressure			
Diabetes			
Thyroid disease			
Asthma/Lung disease			
Liver Disease			
HIV/Hepatitis			
Stroke/Epilepsy			
Kidney/Bladder			
Depression/Psychiatric			
Blood Clots/DVT			
Cancers			
Others			

Allergies

	Yes	No	Details
Allergies			
Are you on Aspirin?			

Medications (including supplements)

Medication name	Reason	Dose

Gynaecological operations

Year	Type of operation	Comment/Complications

Have you ever received a Blood Transfusion? Yes No Details

Past surgical history

Year	Type of operation	Comment/Complications

Vaccination: Have you had the following vaccinations?
COVID……. Y……. N
Influenza…. Y……. N
Whooping Cough……Y……N

Family History of Medical Disorders in the family?
Please list if any of your family members have had any medical problems?
Especially Breast, Ovarian, Uterine, Bowel or Cervix), Diabetes, Hypertension, Congenital diseases in any of the following members:

Mother
Father
Siblings
Children
Grand parents
Uncles/Aunts
Others

Social History

Occupation				
	Yes	**No**	**Amount**	**Duration**
Smoking				
Alcohol				
Recreational drug use				