CONFIDENTIAL **Date:**_____

New Patient Registration Form – Gynaecological

Name:_____ DOB:_____

Address:_____Suburb:_____Postcode:_____

Tel:_____ Mobile:_____ Email:_____

Medicare:_____IRN:_____(position on card) Expiry:_____

Next of Kin: _____ Tel:_____ Relationship_____

GP Name/Clinic: _____ Tel:_____

Gynaecological history for pelvic scan: (This information is essential to aid in the interpretation of possible findings and diagnosis) please provide as much details as possible.

Periods: ☐Regular ☐Irregular how frequently do you get your periods? _____
How many days do you bleed for?_____When was your last menstrual period?_____

Do you get bleeding/spotting in between your periods?_____

Do you suffer from pelvic pain during periods?_____

Do you suffer from pelvic pain in between your periods?_____

Any change in bowel habit before/during your period? (please give details)_____

Do you experience rectal pain/bleeding when you open your bowels around your period? Yes/No

Do you experience bleeding/spotting after intercourse?_____

Do you experience pain during intercourse?_____

Do you experience pain/aching after intercourse?_____

Have you had any pelvic infections in the past?_____

Have you been treated for any Gynaecological problems in the past?_____

_____

Any previous surgery related to gynaecology?_____

Number of previous pregnancies _____How many children?_____

Current contraception: Yes/No Details _____

Any known medical illnesses?_____

Any allergies?_____

Any other information which may be important for us know?

_____

Please tick the box if you do NOT consent to your images to be used for our website or teaching and research purposes. ☐

No disclosure of your personal details will be made on any of the materials used.

PTO

At times it becomes necessary to obtain your previous test results and /or operation records in order to compare the progress or follow up on the findings of your scan today.

Release of Medical Information

I,..... , with a date of birth,…… ,

give my permission for …….. to release my medical records to Dr Anjana Thottungal of Perth Obstetrics and Gynaecology Ultrasound for follow up of my ultrasound.

Patients signature **Date**

Please forward relevant information to

Perth Obstetrics and Gynaecology Ultrasound fax 08 61612260 or bookings@pogu.com.au