POGU
PERTH
OBSTETRICS AND GYNAECOLOGY
ULTRASOUND

CONFIDENTIAL **Date: _____**

New Patient Registration Form – Gynaecological

Name:_____DOB:_____
Address:_____Surburb:_____Postcode:_____
Tel:_____Mobile:_____Email_____
Medicare:_____IRN (position on card)_____Expiry:_____
Next of Kin:_____Relationship_____Tel:_____
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.

Menstrual symptoms (please state if not applicable)
Are you periods: ☐Regular ☐Irregular When was your last menstrual period? _____
How frequently do you get your periods? _____How many days do you bleed for? _____
How heavy is your menstrual bleeding? **NORMAL / SLIGHTLY HEAVY / HEAVY WITH CLOTS**
Do you suffer from pelvic pain during periods? **NIL / MILD / MODERATE / SEVERE**
Do you suffer from pelvic pain between periods? **NIL / MILD / MODERATE / SEVERE**
Do you suffer from ovulation pain? **NIL / MILD / MODERATE / SEVERE**
Do you experience spotting/bleeding between periods**? YES / NO / SOMETIMES**

Symptoms related to intercourse (please state if not applicable)
Do you experience pain during intercourse? **NIL / MILD / MODERATE / SEVERE**
Do you experience pain/ache after intercourse? **NIL / MILD / MODERATE / SEVERE**
How long does the pain after intercourse last? _____
Do you experience spotting/bleeding during/after intercourse? **YES / NO / SOMETIMES**

Bowel symptoms (please state if not applicable)
Do you experience rectal pain? **NIL / MILD / MODERATE / SEVERE**
Do you experience rectal bleeding**? NIL / MILD / MODERATE / SEVERE**
Do you have a history of piles or anal fissure? _____
Do you experience constipation/diarrhoea? **YES / NO / SOMETIMES**
Any change in bowel habit before/during your period? **YES / NO**

Bladder symptoms (please state if not applicable)
Do you experience pain on full bladder? **NIL / MILD / MODERATE / SEVERE**
Do you experience pain on emptying bladder? **NIL / MILD / MODERATE / SEVERE**
Any increase in urinary frequency? **YES / NO** Any urinary urgency? **YES / NO**

Additional information (please state if not applicable)
Have you been treated for any gynaecology problems/pelvic infections in the past?
_____
_____
Any previous surgery related to gynaecology? _____
Is there a family history of endometriosis? _____
Number of pregnancies _____How many children? _____
Current contraception? **YES / NO** Details: _____
Any known medical illnesses? _____
Any allergies? _____
Any other information which may be important to us? _____
_____

POGU is committed to providing our patients with the best possible care. Your images and data will be used to ensure that your treatment is of the highest quality.

With permission, we also use patient images and clinical data for research purposes, the teaching of professionals and on our website as information for future patients. The images and data are kept strictly confidential and your name, date of birth and all other identifying details are removed prior to their use. Please indicate if you are willing for your images and data to be used in this way by ticking one of the boxes below.

☐ Yes ☐ No ☐ I would like to discuss this further with my doctor

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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. This may be for clinical, teaching or research and publication purposes. No disclosure of personal details will be made on any of your medical information accessed.

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