

CONFIDENTIAL Date: _____

New Patient Registration Form - Gynaecological Name: Address:_______Surburb:______Postcode:_____ Mo<u>bile: Email</u> Tel: IRN (position on card) Expiry: Medicare: ______Relationship_______Tel:_____ Next of Kin: Tel:____ GP Name/Clinic:____ 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 <u>bleeding</u>? **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? ____ How many children? Number of pregnancies 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

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

l,,	with a date of birth,
• , ,	to release my medical n Obstetrics and Gynaecology Ultrasound for
Patients signature	Date

Please forward relevant information to

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