DR SARAH WOODBURY
OBSTETRICIAN

HEALTH QUESTIONNAIRE
CONFIDENTIAL

Full Name				
Date of birth				
Occupation				
Partners name				
Occupation				
Your height	cms	Pre pregnancy weight		kgs
LMP (first day of last period)		Usual cycle length		days
Cycle	Do you usually have a regular / irregular cycle			

OBSTETRIC HISTORY

Previous pregnancies	No	Yes	
Outcome	Boy	Girl	Babies name
Gestation	weeks	Babies date(s) of birth	
Hospital			

What type of birth did you have: LSCS/ vaginal birth/ instrumental birth/ epidural block. Did you have any pregnancy related medical issues, (eg gestational diabetes, high blood pressure, pre eclampsia)?

BREASTFEEDING

Did you have difficulty establishing breast feeding?	Yes	No	Not applicable

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QUALITY OF CARE

How do you think the care and management of your previous pregnancy could be improved?

SCREENING TESTS

When was your last pap smear?			
Have you ever had an abnormal pap smear?		Yes	No
Have you ever been diagnosed with genital herpes?		Yes	No

MEDICAL and / or MENTAL HEALTH CONDITIONS

Do you have any medical or mental health conditions?	Yes	No
If yes, please specify:		

CURRENT INTAKE

Cigarettes	Yes	No	If yes, how many per day?	
Alcohol	Yes	No	If yes, how many per day / week?	
Recreational drugs	Yes	No	If yes, what type?	

ALLERGIES

Drug or allergen (eg Penicillin)	
Reaction (eg rash, vomiting, anaphylactic reaction)	

info@drsarahwoodbury.com.au

P 9977 6918 F 9475 5003

PROVIDER NUMBER 206606LJ

LEVEL 5

22 DARLEY ROAD

MANLY NSW 2095

SHOP 8

210 PACIFIC HIGHWAY

CROWS NEST NSW 2065

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RELEVANT FAMILY HISTORY

Please list any family members with a significant medical history, including cancer etc

	Deceased	Alive	Age	Health problems
EXAMPLE *Mother's sister*		*alive*	*40yo*	*breast, bowel or ovarian cancer*
Mother				
Father				

How did you hear about us?	

I have read all questions and the information I have given is correct and complete to the best of my knowledge

Signature of patient				
Date				
Name of patient				

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