WOLLONGONG
OBSTETRICS & GYNAECOLOGY
www.wollongongObGy.com.au

Dr Dharmesh Kothari
MBBS, FRANZCOG
Obstetrician, Gynaecologist,
Laparoscopic & Robotic Surgeon

Patient Registration Form

Welcome to our practice. In order for us to provide the best treatment possible we require the following information.
All personal information will be handled with strict confidentially.

Type of Patient:	☐ New ☐ Existing - please update details if changed
Title:	☐ Mrs ☐ Ms ☐ Miss ☐ Dr
Given Name:	
Family Name:	
Preferred Name:	
Address:	
	Postcode:
Date of Birth:	
Telephone:	H: W: M:
Email address:	
Medicare Card No:	Ref No: Expiry Date:
Private Health Insurance:	☐ Yes ☐ Uninsured Fund Name: Membership No:
Pension Card:	☐ Yes ☐ No Card Number: Expiry Date:
Referring Doctor:	
Usual Doctor:	
Marital Status:	☐ Married ☐ Single ☐ Defacto ☐ Same Sex Partner ☐ Widowed ☐ Divorced ☐ Separated
Occupation:	
Emergency contact:	☐ Partner ☐ Father ☐ Mother ☐ Other (Please Specify)
	Name: Telephone:
	Occupation:
Spouse: (if different)	Name: Telephone:
	Occupation:

Do you consent to having an internal ultrasound if required: ☐ Yes ☐ No

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Name: _____ **D.O.B:** ___ / ___ / ___

ALLERGIES/REACTIONS: _____ **NIL / YES - details below** (MEDICINE / ADHESIVE TAPES / FOODS)

LAST PAP SMEAR: DATE ___/___/___ Normal or Abnormal | TREATMENT: _____

PAST MEDICAL HISTORY: **NIL / YES - details below**

eg. Asthma, Heart Disease, Gastrointestinal problems, Kidney Disease/UTI, Epilepsy, Thyroid Disease, Significant childhood illnesses.

TREATMENT REQUIRED: _____

PAST PSYCHIATRIC HISTORY: **NIL / YES - details below**

eg. Depression/Anxiety, Eating/Sleeping Disorders, PND.

TREATMENT REQUIRED: _____

PAST SURGICAL HISTORY: **NIL / YES - details below**

Local or General Anesthetic. _____

PAST GYNAECOLOGICAL HISTORY: **NIL / YES - details below**

eg. Cervix abnormalities, Fertility issues, Investigations, PCO, PID.

TREATMENT REQUIRED: _____

FAMILY HISTORY: **NIL / YES - details below**

eg. Diabetes(T1/T2), Thyroid Disease, Heart Disease, Stroke, Blood Pressure problems, Congenital/Genetic Disorders, Psychiatric illness.

_____

CURRENT MEDICATION: **NIL / YES - details below**

eg. Please include any prescription/over the counter/vitamins/folate that you are currently taking.

_____

DO YOU SMOKE? NO / YES **Amount:** _____ | **DO YOU DRINK ALCOHOL?** NO / YES **Amount:** _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? NO / YES | Year: _____ Reason: _____

WHAT SORT OF DIET DO YOU HAVE? _____

DO YOU EXERCISE? NO / YES | Type: _____

WHAT IS YOUR HEIGHT? _____ | **WHAT WAS YOUR PRE-PREGNANCY WEIGHT?** _____

PREVIOUS PREGNANCIES (new patients only)	Pregnancy 1	Pregnancy 2	Pregnancy 3	Pregnancy 4
Date				
Place (name of hospital)				
Gestation (weeks)				
Outcome (eg. Live birth/Miscarriage/TOP)				
Labour (eg. Spontaneous/Induced)				
Duration of Labour				
Analgesia (pain relief)				
Birth Type (eg. normal/forceps/caesarean)				
Baby Weight				
Baby Sex				
Baby Name				
Feeding Method				