

Gynaecology Questionnaire

CARMEL COCCHIARO
OBSTETRICIAN & GYNAECOLOGIST

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Surgical history

Anaesthetic history

Previous anaesthetic problems
Dental health & jaw problems
Back problems
Blood transfusion
Other

Past pregnancy information

Use * to indicate sensitive information not recorded here. Age ____ Gravidity ____ Parity ____

*	Date	Place	Gestation	Labour, birth & postnatal details	Birth Weight	Gender	Feeding Type & Duration	Babys Name

Psycho - Social History

- Anxiety/depression
- Emotional issues
- Relationship issues
- Financial issues
- Postnatal depression
- Major stressors, life changes or losses
- Contact with Families SA
- Other
- Other psychiatric disorders
- Mental health problems
- Accommodation issues

Family History

Diabetes _____

Heart Disease _____

High Blood Pressure _____

Genetic Disorders / Congenital Abnormalities _____

Other _____

Please tell us the reason/s for your visit: _____

How did you find out about Dr. Carmel Cocchiaro? _____

This information is strictly confidential, once entered into your file, this document will be destroyed.