Full Circle
OBSTETRICS & GYNAECOLOGY

Dr Preetam Ganu
MBBS MD FRANZCOG
Suite 2, Tennyson Centre
520 South Road, Kurralta Park SA 5037
Ph: 08 8299 0302 Fax: 08 8299 0893
Email: flindersobgyn@gmail.com
Web: www.drpreetamganu.com.au

OBSTETRIC QUESTIONAIRE

Title:	Dr	Mr	Mrs	Ms	Miss	Other	Date of Birth:	
Surname:							Given Name:	

PREGNANCY HISTORY: Number of pregnancies including miscarriages, terminations, ectopic pregnancies, and deliveries.

Year	Place	Gestation (weeks)	Labor, Birth & Post Natal Details	Birth Weight	Gender	Breast/Bottle	Name

MEDICAL & SURGICAL DETAILS:

Year of Diagnosis	Medical Condition	Treatment including Surgeries	Complications including Anesthetic

MEDICATION HISTORY:

Medication	Dose	Frequency	Reason for taking and duration

**Allergies	Describe in detail the reaction

Do you smoke?	Yes		No		Drink Alcohol?	Yes		No	
Are you an ex-smoker?	Yes		No		If yes, standard drinks	per week			
Do you take recreational or illicit drugs?	Yes		No		Have you been exposed to hazardous materials?	Yes		No	
If yes, what type?					If yes, what materials?				

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FAMILY HISTORY: Including genetic disorders, cystic fibrosis, cancers and blood/bleeding disorders

Person	Condition(s) or Disease(s)	Treatment(s)	Outcome

OTHER INFORMATION:

Other information you may wish to provide OR issues you may wish to address OR your expectations:

Remember to forward your completed New Patient Information Form and your completed Questionnaire back to us.

This will enable Dr Preetam Ganu to review prior to your appointment.
by fax 08 8299 0893 or email flindersobgyn@gmail.com