

Patient registration

Pre-pregnancy

Date completed: _____

Patient name: _____ Date of birth: _____

Pregnancy plans and goals. What would you most like help with?

For example: general preparation, medicine review, fertility, genetic risk or planning around a health condition:

When would you ideally like to conceive? ☐ Now ☐ Within 3 months ☐ 3-12 months ☐ More than 12 months ☐ Unsure

Are you currently trying to conceive? ☐ No ☐ Planning fertility treatment ☐ Prefer to discuss ☐ Yes: _____ (for how long)

Current contraception: ☐ None ☐ Pill ☐ IUD ☐ Implant ☐ Barrier ☐ Other: _____ Planned stop/removal: _____

Could you currently be pregnant? ☐ No ☐ Yes ☐ Unsure ☐ Not applicable

Periods and reproductive health:

First day of your last menstrual period: ☐ Unsure ☐ Not applicable Date: _____

Usual cycle: ☐ Regular ☐ Irregular ☐ No periods ☐ Unsure Usually every _____ days.

Relevant diagnoses: ☐ Endometriosis ☐ Adenomyosis ☐ Fibroids ☐ PCOS ☐ Ovarian cysts ☐ Infertility/recurrent pregnancy loss

☐ Pelvic infection/STI ☐ Other: _____

Fertility tests or treatment already undertaken: ☐ None ☐ Tests ☐ Ovulation induction ☐ IUI ☐ IVF ☐ Brief details/outcome: _____

Cervical screening: ☐ Never ☐ Unsure Last test: _____ Result/follow-up: _____

Previous gynaecological procedures or surgery: ☐ None ☐ Yes, brief details/year: _____

Previous pregnancies (if applicable):

Pregnancy summary: Pregnancies: _____ Births: _____ Miscarriages: _____ Ectopic: _____ Terminations: _____ Living children: _____

Previous births: ☐ Vaginal birth ☐ Assisted vaginal birth ☐ Caesarean ☐ Not applicable

Significant previous pregnancy or birth complications: ☐ None ☐ High blood pressure/pre-eclampsia ☐ Gestational diabetes

☐ Heavy bleeding/transfusion ☐ Placental problem ☐ Severe tear ☐ Baby growth problem ☐ Stillbirth/neonatal loss ☐ Preterm birth

☐ Other: _____

Anything from a previous pregnancy you particularly want to discuss? ☐ No ☐ Yes ☐ Prefer to discuss privately

Health and medicine review:

Medical conditions: ☐ High blood pressure or heart condition ☐ Diabetes — type 1 or type 2 ☐ Thyroid or other endocrine condition

☐ Epilepsy or other neurological condition ☐ Asthma or significant respiratory condition ☐ Kidney or liver disease

☐ Autoimmune condition or reduced immunity ☐ Previous blood clot, bleeding/clotting or blood disorder

Health and medicine review (cont.):

☐ Blood-borne virus or other chronic infection ☐ Prefer to discuss privately ☐ Other condition requiring specialist care:

Height and weight: Height (cm): _____ Weight (kg): _____ ☐ Unsure

Previous operations: ☐ None ☐ Caesarean ☐ Uterine/cervical surgery ☐ Abdominal/pelvic surgery ☐ Other, brief details/year:

Current medicines, vitamins and supplements: ☐ None ☐ Folic acid ☐ Prenatal vitamin List names/doses if known:

Allergies or medicine reactions: ☐ None known ☐ Yes, list allergy & reaction:

Regular specialist care: ☐ None ☐ Yes, specialty/clinician: _____

Immunity and health preparation – Vaccination or immunity status (if known):

Rubella: ☐ Immune/vaccinated ☐ Not immune ☐ Unsure

Varicella: ☐ Immune/vaccinated ☐ Not immune ☐ Unsure

Hepatitis B: ☐ Immune/vaccinated ☐ Not immune ☐ Unsure

Recent checks or screening: ☐ Vaccination record available ☐ Recent blood tests ☐ Carrier screening undertaken ☐ None/unsure

Details: _____

Lifestyle, wellbeing and family history:

Smoking: ☐ No ☐ Yes ☐ Recently stopped ☐ I would like support to reduce or stop

Vaping: ☐ No ☐ Yes ☐ Recently stopped ☐ I would like support to reduce or stop

Alcohol: ☐ None ☐ Yes ☐ I would like support to reduce or stop ☐ Approximate amount/week: _____

Other substance use: In the past 12 months, have you used recreational or non-prescribed substances, or medicines other than as directed?

☐ No ☐ Yes, brief details: _____ ☐ Prefer to discuss privately

Mental health, neurodivergence and supports: ☐ No current concerns ☐ Anxiety/depression ☐ ADHD ☐ Autism

☐ Current professional support ☐ Other: _____

Anything that would help your care? _____

Family/genetic history in either genetic parent or donor: ☐ None known ☐ Inherited/genetic condition ☐ Birth difference

☐ Intellectual disability ☐ Recurrent pregnancy loss/stillbirth ☐ Blood clotting disorder ☐ Other: _____

Supporting your care – Is there anything you would like us to know before the consultation or examination?

For example: communication or accessibility needs, a support person, previous difficult examinations or trauma, or a preference to discuss something privately:



Urgent symptoms?

This form is **not monitored for urgent concerns**. If you have severe or rapidly worsening pain, very heavy bleeding, feel faint or acutely unwell, **seek urgent medical care** or **call 000**.