ABN 15 817 932 007

Dr Yen-Yung Yap

MBBS (Adel), FRANZCOG, MRMed

Address: **680 South Road, Glandore SA 5037**

Postal: PO Box 225, Edwardstown, SA 5039

Phone 08 82974338 / 0422 014 044

Fax 08 8297 5823

Email booking@yapspecialist.com.au

Hi,

Thank you for choosing us to provide you specialist care. To assist us in providing you a prompt and effective service, would you mind filling out the questionnaire form as attached below? Once we receive your fill-out questionnaire form, we shall contact you to confirm your appointment date and shall endeavour to book you in within 2 weeks' time. Should you have any difficulties answering some of the questions, feel free to discuss this with us when you come in for your first appointment. You may return the form by mail, using the reply envelope provided, preferably within 5 days prior to your preferred date of appointment. You may also return the form via fax or email, if this method is of convenience to you.

Please try to arrive at least 15min before your appointment time to complete our registration. If you were running late for your appointment, we would appreciate your courtesy call of such event.

On that day, the things to remember bringing in are:

- Your doctor's referral letter;
- The original filled-out Questionnaire form if not already returned by mail;
- Copy of all pathology results and imaging films & report if you have them;
- Your Medicare card, Health fund card, and photo ID card (e.g. driver's licence, passport); and
- Cash, bankcard or credit card depending on your preferred payment method. Note, for electronic payment, we accept EFTPOS, Visa and MasterCard only.

For further enquiries, please feel free to email us (at booking@yapspecialist.com.au) or ring the practice (at 08 8297 4338) during office hours (Mon-Fri, 9am till 5pm).

We look forward to seeing you on the day.

Warm regards,

Ms Mei-Khing Loo
Practice Manager

Yap Specialist
ABN 15 817 932 007

Dr Yen-Yung Yap
MBBS (Adel), FRANZCOG, MRMed

Title: ..... Surname: ..... Given Name: .....

Preferred Name: ..... Date of Birth: .....
DD / MM / YYYY

Name of Next-of-kin: ..... Relationship: .....

Marital status: ☐ married ☐ de facto ☐ single ☐ same sex couple
Please tick the most appropriate one

Postal Address: ..... Post code: .....
Street number & name, Suburb, State

Phone Number: ..... Mobile phone: .....
(area code) 0000 0000 0400 000 000

Email address: .....

Preferred mode of communication: Mobile phone / Home phone / Office phone / SMS / Email
Please indicate order of preference
and state 'No' to the ones you object ☐ ☐ ☐ ☐ ☐

Occupation: .....

Where did you hear from us: ☐ doctor ☐ word of mouth ☐ social media ☐ website
Please tick the most appropriate ☐ others, please specify: .....

Name of your usual / referring doctor: .....

Address of your doctor's practice: .....
Street number & name, Suburb, State, Postcode

Emergency contact

Name: ..... Relationship: .....

Phone/mobile number: .....

Medicare No: ☐☐☐☐ ☐☐☐☐☐ ☐ ☐ Expiry: MM / YY

Health Fund: .....

Health Fund number: ..... Expiry: MM / YYYY

Partner's Detail

Title: ..... Surname: ..... Given Name: .....

Preferred Name: ..... Date of Birth: .....
DD / MM / YYYY

Postal Address: ..... Post code: .....
Street number & name, Suburb, State

Phone Number: ..... Mobile phone: .....
(area code) 0000 0000 0400 000 000

Email address: .....

Preferred mode of communication: Mobile phone / Home phone / Office phone / SMS / Email

☐ ☐ ☐ ☐

Please indicate order of preference and cross out ones you object

Occupation: .....

Name of your usual / referring doctor: .....
Fill in if different from the above

Address of your doctor's practice: .....
Street number & name, Suburb, State, Postcode

Medicare No: ☐☐☐☐ ☐☐☐☐☐ ☐ ☐ Expiry: MM / YY

Health Fund: .....

Health Fund number: ..... Expiry: MM / YYYY

Fertility history:

How long (months/years) have you been trying to conceive? How many times a week do you usually have unprotected intercourse?

Previous fertility assessment and treatment:

List out the investigations and treatments – specify the dates & location, results/outcome, name of gynaecologist(s). Remember to bring in copy of results and letters

Date of first day of your last menstrual period: DD/ MM / YYYY

Menstrual cycle: ☐ Regular ☐ Irregular

Please tick one

How many days do your menstrual cycles usually take?

From beginning of one period to the beginning of the next period .....

Do you have the following symptoms? *Please tick your answer, more than one if applicable*

☐ Heavy period ☐ painful period ☐ intermenstrual spottings ☐ bleeding after sex

Have you used any form of contraception? *If yes, please specify the type and period of use.*

.....

Gynaecological history:

Conditions; treatments; date (month & year) of diagnosis and treatment

Date of Last PAP smear: MM / YYYY Results: .....

Previous abnormal PAP: Yes / No If yes, what year? .....

Previous HPV vaccination Yes / No

Date of last sexually transmitted disease screening: MM / YYYY Results: .....

Pregnancy history:

Total number of pregnancies; the number of miscarriages, terminations, ectopic pregnancies, deliveries (specify whether you have natural birth, instrumental delivery or caesarean section; any labour complications); the dates (month & year); and location

Medical & surgical history:

Conditions; treatments; date (month & year) of diagnosis and treatment; surgical/anaesthetic complications

Medications:

Type, dosage, frequency and route; including alternative/herbal medicines & supplements

Drug allergies: .....

Do you smoke, drink alcohol, or take recreational drugs? Have you been expose to hazardous materials?

If yes to any of the above, please specify type, amount and period of exposure

Family history:

Including genetic diseases, cystic fibrosis, cancers and blood/bleeding disorders

Partner's Health Detail

Have you been involved in any previous pregnancies? Yes / No

If yes, please state the number, date (month & year), and the pregnancy outcome

Previous fertility assessment and treatment:

List out the investigations (including semen analysis) and treatments – specify the dates & location, results/outcome, name of specialist(s). Remember to bring in copy of results and letters

Medical & surgical history:

Conditions incl. erectile/ejaculation problem, genital trauma/surgery/infection; prostate disease; hypertension, heart diseases, diabetes; inguinal hernia repair; date (month/year) of diagnosis & treatment; surgical/anaesthetic complications

Date of last sexually transmitted disease screening: MM / YYYY Results: ……

Medications:

Type, dosage, frequency and route; incl. Menevit, anti-hypertensives, alternative/herbal medicines & supplements

Drug allergies: ……

Do you smoke, drink alcohol, or take recreational drugs? Have you been expose to hazardous materials?

If yes to any of the above, please specify type, amount and period of exposure

Family history:

Including genetic diseases, cystic fibrosis, cancers and blood/bleeding disorders

In the last 12 months: *Tick the boxes describing the things you have done. Remember to bring in copy of the results/letters*

- ☐ Any blood tests
- ☐ Any radiology tests including ultrasound scan, hysterosalpingogram
- ☐ Semen analysis
- ☐ Seen other specialists

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

Tick one or more boxes describing your expectations

Your expectations	Recommended session time
☐ A comprehensive and detailed assessment covering all relevant women's health issues, fertility and long term health ☐ A detailed explanation of my condition(s) ☐ Discussion on the various management options / choices available ☐ A holistic and individually-tailored management plan	First consult: 45-60 min Review consult: 30-60 min
☐ A focused assessment & management based on a complex area of concern	First consult: 30-45 min Review consult: 30 min
☐ A focused assessment based on a minor area of concern ☐ A second opinion ☐ A basic / simplified explanation ☐ Doctor to decide my management on my behalf following standard practice ☐ A budget conscious management plan, i.e. one which incurs the least gap	First consult: 30 min Each consult: 15-30min
☐ Onsite ultrasound scan on the day of consult. [Note: Medicare rebate for ultrasound scan will be reduced by $ 35 if combined with consult]	Additional 30 min