Chrysalis
Obstetrics & Gynaecology

Thank you for taking time to complete this form. It is used to make your visit with us at Chrysalis more efficient - fill in as much as you feel comfortable sharing.

Name:
Pronoun(s):
Relationship status:

Legal name:
Date of Birth:
AB Health Care #:

Why are you seeing us today?

Any current health conditions?

Have you had any of the following:

_ heart disease/heart attack
_ kidney disease
_ lung disease
_ high blood pressure
_ diabetes
_ depression or anxiety
_ substance use problems
_ neurological disease/stroke/seizures
_ liver disease
_ blood clot (DVT, pulmonary embolism)
_ thyroid disease
_ bone or joint problems
_ other mental health issues
_ other:

Please list any prescription medications:

Please list any over the counter medications:

Please list any herbal or natural medications:

Do you have any medication allergies?

Do you smoke cigarettes/e-cigarettes/vape/marijuana?

Please list any surgeries in the past:

Do you require contraception - if so what do you use?

Have you ever been pregnant - if so how many times and how did they go?

Do you have any children?

Have you undergone Pap testing - if so when was your most recent?

Any abnormal Pap tests in the past?

Have you had a sexually transmitted infection?

When was your last menstrual period?

Do you feel safe at home?

Is there anything else you would like us to know or questions you would like answered today?

Please know that we respect your confidentiality - all staff and learners sign a confidentiality agreement. A note generally goes back to your referring physician/ nurse/midwife. Should you wish any of this written or other disclosed information not be shared please let us know.