Height: ______________________

PATIENT HISTORY

Appointment date: ______________________

Name: ________________________ **Age:** _____ **DOB:** _____________ **AHC/PHN#:** __________________

Address: ____**Postal Code**___________________

Tel (Home):_______________________**(Work):**_______________________**(Cell):**________________________

Why have you come to see the doctor: ____

____

How long has this been ongoing: ____

____

Any previous treatment: ____

____

GYNECOLOGICAL HISTORY

Age periods started: _____________________
First day of last menstrual period: _____________________
How many days from the start of one period to the start of the next period: _____________________
How many days of flow with each period: _____________________
Do you have bleeding between periods: _____________________
Do you have severe period cramps: _____________________

Do you have any symptoms of menopause (hot flushes, vaginal dryness, insomnia, mood changes): ___________
Have you ever taken hormone replacement: _____________________ What kind: _____________________

Date of last Pap test: ___________________ Result: _____________________
Regular yearly Pap tests: ________________ Any abnormal results in the past: _____________________

Are you sexually active at present: _____________________
Are you having any sexual problems: _____________________
Do you have pain with intercourse: _____________________ bleeding with intercourse: _____________________
Have you had any sexually transmitted diseases: _____________________
Present birth control: ___________________ In the past: ____

Are you having any problems with your partner: _____________________
Have you ever been physically or emotionally abused or assaulted: _____________________

OBSTETRICAL HISTORY

Total number of: Pregnancies: _______Children: _______Miscarriages: ______Abortions: ______Ectopics: ______

DDMMYY	Hospital	Gest Age	Hours In Labour	Delivery Type	Complications	Sex	Weight

SURGICAL HISTORY

Year **Hospital** **Operation**

____ ____________ ____

____ ____________ ____

____ ____________ ____

____ ____________ ____

PATIENT HISTORY

Name: ____________________________

MEDICAL HISTORY

Have you ever had any of the following: Heart problems/Rheumatic fever, High blood pressure, High cholesterol, Asthma/Lung problems, Bladder infections/Kidney problems, Seizures/Epilepsy, Thyroid disease, Diabetes, Phlebitis/Blood clots, Abnormal bruising or bleeding disorders, Anemia , Blood transfusion, Depression/Psychiatric disorder, Hepatitis/Liver problems, Stomach ulcers, Gallbladder problems, Chronic constipation/diarrhea, Cancer, Breast lump/tenderness, Mammogram, Bone density test, Tests for HIV & Result, Problems with anesthetics, or any other medical conditions:

Year	Condition	Treatment
____	__________________	____
____	__________________	____
____	__________________	____
____	__________________	____
____	__________________	____

MEDICATIONS

Dates	Medication	Dosage	Route	Frequency
____	____________	____________	____________	____
____	____________	____________	____________	____
____	____________	____________	____________	____
____	____________	____________	____________	____
____	____________	____________	____________	____

ALLERGIES

Drug	Reaction
____________	____
____________	____

SOCIAL HISTORY

Occupation: ___________________________

Do you drink coffee: ____________________ Cups/day: ___________________________

Do you use tobacco: ___________________ Cigarettes/day: _______________________

Do you use alcohol: ____________________ Drinks/day: __________________________

Have you ever used street drugs: _________ What kind: __________________________

FAMILY HISTORY

Have any of your relatives had Problems with anesthetics, Diabetes, Heart disease, Strokes, Hypertension, Osteoporosis, Cancer (What kind), Congenital Anomalies, Mental Retardation, Twins or any other conditions:

Relative	Condition
____________	____
____________	____
____________	____
____________	____
____________	____

ANY OTHER PROBLEMS NOT LISTED ABOVE

____

____

____