Grandview Gynecology

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Form G-1 A. 230524

Patient History

Demographic Information

Surname	Given names	Date of birth	Age	Today's date

Personal Health Number	Preferred contact number	Preferred appointment reminder method
		Please select...

Address	Email	Like to receive email newsletter? ☐ Yes

Reason for your visit today	Treatments you've tried for this problem

Obstetric History

Number and birth types (vaginal, cesarean) of children

Gynecologic History

Do you get a monthly period?	Do you have pain with sex?	Have you ever been physically or sexually harmed? ☐ Yes
Please select...	Please select...	

Year of menopause	- or -	First day of last period	Year of last Pap	Any abnormal Paps in the past? ☐ Yes

Prior gynecologic history (hormone therapy, D&Cs, biopsies, etc.)	Any menopausal symptoms?
	☐ Hot flashes ☐ Vaginal dryness ☐ Incontinence ☐ Urinary urgency ☐ Urinary frequency ☐ Frequent bladder infections ☐ Mood changes ☐ Weight gain ☐ Low sexual desire ☐ Insomnia ☐ Joint or bone pain (arthritis) ☐ Back pain ☐ Other:

Social History

Relationship status	Occupation

General Medical History

Current or previous medical conditions

☐ **Heart attack or stroke** ☐ **High blood pressure** ☐ **Blood clotting disorder** ☐ **Easy bleeding**
☐ **Lung disease** ☐ **Liver issues** ☐ **Kidney issues** ☐ **Bladder problems** ☐ **Bowel problems**
☐ **Thyroid issues** ☐ **Autoimmune disease** ☐ **Depression** ☐ **Anxiety** ☐ **Addiction** ☐ **Migraines**
☐ **Diabetes** ☐ **Cancer:** _____ ☐ **Other conditions:** _____

Current medications (include doses)	Surgical history
Preferred pharmacy (include name and location)	Allergies (any type)

Medical problems or cancers in family

Height	Weight	Year of last mammogram	Year of last colonoscopy	Abnormal screening result in past? ☐ **Yes**

Alcoholic drinks per week	Cigarettes per day	Other drug use

Office Policies

Missed appointments delay care for all patients. Late cancellations and missed appointments may be assessed a fee if we are given less than **2 business days notice**. This fee is **$100** for a consultation appointment and **$50** for a follow-up appointment.

Please sign below to indicate that you have read and understood this information.

Patient signature *(electronic form — complete name field only)*	Print name	Date