

Form
G-1
A. 230524

Patient History

Demographic Information

Surname	Given names	Date of birth YYYY - MM - DD	Age	Today's date YYYY - MM - DD
Personal Health Number	Preferred contact number () -	Preferred appointment reminder method <input type="checkbox"/> Text <input type="checkbox"/> Call <input type="checkbox"/> Email		
Address	Email	Like to receive email newsletter? <input type="checkbox"/> Yes		
Reason for your visit today		Treatments you've tried for this problem		

Obstetric History

Number and birth types (vaginal, cesarean) of children
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Gynecologic History

Do you get a monthly period? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have pain with sex? <input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never	Have you ever been physically or sexually harmed? <input type="checkbox"/> Yes		
Year of menopause	- or -	First day of last period YYYY - MM - DD	Year of last Pap YYYY	Any abnormal Paps in the past? <input type="checkbox"/> Yes
Prior gynecologic history (hormone therapy, D&Cs, biopsies, etc.)		Any menopausal symptoms? <input type="checkbox"/> Hot flashes <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Incontinence <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Frequent bladder infections <input type="checkbox"/> Mood changes <input type="checkbox"/> Weight gain <input type="checkbox"/> Low sexual desire <input type="checkbox"/> Insomnia <input type="checkbox"/> Joint or bone pain (arthritis) <input type="checkbox"/> Back pain <input type="checkbox"/> Other:		

Social History

Relationship status	Occupation
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General Medical History

Current or previous medical conditions <input type="checkbox"/> Heart attack or stroke <input type="checkbox"/> High blood pressure <input type="checkbox"/> Blood clotting disorder <input type="checkbox"/> Easy bleeding <input type="checkbox"/> Lung disease <input type="checkbox"/> Liver issues <input type="checkbox"/> Kidney issues <input type="checkbox"/> Bladder problems <input type="checkbox"/> Bowel problems <input type="checkbox"/> Thyroid issues <input type="checkbox"/> Autoimmune disease <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Addiction <input type="checkbox"/> Migraines <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer: _____ <input type="checkbox"/> 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 YYYY	Year of last colonoscopy YYYY	Abnormal screening result in past? <input type="checkbox"/> 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	Print name	Date YYYY - MM - DD
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