STICKER

Well Women Clinic

Petawawa Centennial Family Health Centre

Date completed______________________ Revised___________________________

Gynecology		
Menstrual history	Age of first period?	Are your current periods regular?
How long do they last?	Is the flow Light? Moderate? Heavy?	
Is there pain? Mild? Moderate? Severe?	**Date of Last period**?	
Do you experience spotting between periods?	Was your last period normal?	
Pap History	Have you ever had an abnormal pap? N Y If so when?	
Did you have a colposcopy? N Y Where ?	Did you have further treatment after the colposcopy?	
When was your last pap?	Was it normal? N Y	

Sexual History	Are you currently sexually active? N Y
Have you ever been sexually active? N Y	Do you have pain with intercourse? N Y
Birth Control	Are you currently using birth control? N Y If yes what method?
Have you used birth control in the past? N Y If yes what? And when?	
STI's	Have you ever had Herpes, Chlamydia, Syphilis, Genital Warts, HIV/AIDS , Hepatitis B or HPV? N Y If so which one(s) When /how were you treated?

Pregnancy History	Number of pregnancies? Number of live births?	
Number of miscarriages/ abortions?	Any history of ectopic pregnancies/tubal pregnancies? N Y	
Have you ever had a c-section? N Y	Any pregnancy complications?	
Are you currently pregnant? N Y	Are you looking at a pregnancy soon? N Y	
Infertility	Have you had difficulty getting pregnant? N Y	Have you been treated
for infertility? N Y Is so, which treatments and when?		

Menopause	Are you menopausal (no menses for 1 year)? N Y If so please answer the following
Are you bothered by hot flashes night sweats, or trouble sleeping? Have you ever taken hormone replacement? N Y	Do you take herbs/ supplements for menopause? N Y
Have you ever had a bone mineral density test? N Y	When was the last one?
Do you have any spotting or bleeding?	
Are you on Vitamin D? How much? Are you on calcium? How much?	

Past Gynecologic History:	Have you ever had any of the following? Please circle and give details below:.
Fibroids Ovarian Cysts Endometriosis Pelvic infections Uterine surgery Hysterectomy Laparoscopy D&C Ovarian or tube removal	
Details	

Breast Health	Have you ever had a mammogram or breast ultrasound? N Y If so
when / results?	Have you had a breast biopsy/
or any breast surgery? N Y If so when/ what?	
Are you having any nipple discharge, soreness, palpable lumps? N Y	

Bladder Health	Do you have pain with urination? N Y
Do you have frequent Urinary track infections? N Y	Do you leak urine when you cough, sneeze or laugh? N Y
Do you urinate frequently? N Y	Do you get up at night to urinate? N Y If so how often?
Any other urinary problems/ conditions?	

General Health Questions
Allergies:
Current **medications**:
Do you **Smoke**? N Y How many a day?
Immunizations: When was your last tetanus shot?
Have you had the Gardasil series? N Y If not are you interested in receiving it?

Medical History: If you have or have had any of the following conditions please circle and give details: Blood clots Migraines (with aura) Diabetes High blood pressure Breast cancer Endometrial Cancer Liver Disease Jaundice Ischemic heart disease Stroke Thrombophillia Bleeding disorder Atrial Fibrillation Other:

Details:

Family History : If any of your family members have the following conditions, please circle and describe below:
Blood clots Stroke High blood pressure Diabetes Breast cancer Uterine / cervical cancer Heart disease Any bleeding disorders
Details?