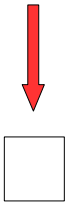
CALGARY WELL WOMAN CLINIC PATIENT INFORMATION

Today's date: _____ Have you been here before? _____ Last visit here: _____

ALERT! Is your information correct? If yes, check box. If not, please bring to the attention of staff immediately.



Office use Only:
Place Label Here

Reason for visit

_____

_____

_____

_____

MEDICAL PROBLEMS/HOSPITALIZATIONS / PAST SURGERIES
(If you have been here before only note changes since last visit)

_____

_____

_____

WOMENS HEALTH

Pregnancies_____/ # Children_____ Are you pregnant now? _____
First day of last period _____/ Last PAP_____
Any abnormal PAPs? _____
Is this your post pregnancy PAP? Yes or No

Are you on any MEDICATIONS? Yes or No (If Yes, please list)
Name Dose How many times a day?

_____

_____

_____

Do you have any ALLERGIES? Yes or No (If Yes, please list)

_____

_____

FAMILY HISTORY (circle those that apply and give the persons relationship to you)

Cancer: Breast _____ Ovaries _____
Other _____
Heart attacks _____
Diabetes _____
Other _____

SOCIAL HISTORY

Smoke (start age, quit age and # packs per day) _____
Alcohol (how many) _____
Drugs (IV, other) _____

FAMILY PHYSICIAN

Do you have a family doctor that you would like us to send copy of results? Yes or No
If so, please provide doctor's name & location:_____
_____
_____

Office Use Only

- Pap ☐
- GC/Chlam ☐
- Yeast/BV ☐
- Trich ☐
- B/W ☐
- Prov. Lab ☐
- Preg. Lab ☐
- Urine ☐
- U/S ☐
- Mam. ☐
- BMD ☐

Other_____

I understand that results & prescriptions will not be given over the phone ☐ (check box).

I would like my follow up appointment to discuss results to be: ☐weekday ☐evening ☐weekend