

Women's Health Patient Intake Form

Date: _____

Name: _____	Age: _____	Date of Birth: _____	Postal Code: _____
Address: _____		City: _____	
Home Phone: (____) _____		Work Phone: (____) _____	
Emergency Contact : _____		Phone: _____	
Occupation: _____		Email: _____	

Referral Source (please circle any/all which apply)

- | | |
|--------------|-------------------------------------|
| Yellow Pages | Other media (TV, Newspaper article) |
| Website | Health Care Practitioner _____ |
| Street Sign | Friend/Family _____ |

Please list any health conditions you would like help with (in order of importance to you)

1. _____
- 2.. _____
- 3.. _____
- 4.. _____
- 5.. _____

What medications, treatments or supplements are you currently taking?

- | | | |
|-------|--------------|------------------------------|
| _____ | since: _____ | side effects/benefits: _____ |
| _____ | since: _____ | side effects/benefits: _____ |
| _____ | since: _____ | side effects/benefits: _____ |
| _____ | since: _____ | side effects/benefits: _____ |

Please circle yes or no, or fill in blank:

- Number of pregnancies _____ Number of live births _____
- Did you breastfeed your children and if so total # of years/mths: _____
- Age you began your menses: _____ Date of last menstrual period: _____
- Are you menopausal? ____ Natural menopause or hysterectomy? _____
- If not menopausal:
- Length of menstrual cycle (ie: 28 days): _____ (if irregular please note)
- Length of period (ie 5-6 days) _____
- Menstrual flow(circle one) very light light medium heavy very heavy
- Are you aware of your time of ovulation? _____
- What method do you use to measure ovulation if any? _____

Mark off which apply to you: use an N for now, or a P for past

Fibroids	Ovarian cysts	Polycystic Ovary	Irregular Cycle
Blocked tubes	Pelvic Inflam Ds	Genital Herpes	Gyn/Breast Cancer
Frequent yeast or urinary infections	Endometriosis	Painful Menses	Hot Flashes
Uterine Prolapse	Anatomical Issue with Uterus	Retroversion/flexion of uterus	Thyroid Disease

What surgeries/hospitalizations have you had?

<i>Type of Surgery/Hospitalization reason</i>	<i>Date/Year</i>	<i>Any Complications</i>

Have you lost? or gained? any weight recently? Y N How many pounds? _____
 What exercise do you do and how much? _____

How much of the following are you using?

Tobacco:	Alcohol:
Coffee/Non herbal Tea:	Recreational Drugs:

Which of the following conditions have you had? Place a N in the box for Now, and a P in the box for Past.

	Abscesses		Diabetes		Herpes Genitalia		Parasites		Other STDs		Vaginal Dryness
	Alcoholism		Emphysema		High Cholesterol		Pelvic Inflammatory D.		Skin Disease		Warts
	Allergies		Epilepsy		IBS		Peritonitis		Strep Throat		Whooping Cough
	Anxiety		Gall Stones		Kidney Disease		Pleurisy		Sinusitis		Worms
	Arthritis		Goitre/Thyroid		Low libido		Pneumonia		Sunstroke		Yellow Fever
	Asthma		Gonorrhea		Malaria		Pain with Intercourse		Stroke		Other(list here)
	Cancer		Gout		Migraines		Rheumatic Fever		Syphilis		
	Chicken Pox		Hay Fever		Miscarriage		Rubella		Tonsillitis		
	Cold Sores		Heart Disease		Mononucleosis		Scarlet Fever		Tuberculosis		
	Depression		Hepatitis		Mumps		Sexual Abuse		Typhoid Fever		

ANY OTHER MAJOR CONDITIONS? _____
 Are there any of the preceding conditions after which you have never been totally well again or which have been more severe than usual? Which ones? _____

Please indicate below, which of the following ailments have affected your relatives?

Please use F for father, M for mother, S for sibling, C for child or E for extended relative

Alcoholism	Asthma	Diabetes	Gout	Mental Illness	Skin Disease
Allergies	Cancer	Epilepsy	Hay Fever	Paralysis	Syphilis
Arthritis	Depression	Gonorrhoea	Heart Disease	Pneumonia	Tuberculosis

Do you have any dietary restrictions? (vegetarian/vegan, religious, food allergies/intolerances etc.)
