WOMAN'S HEALTH OPTIONS
(No previous Chart)

IDENTIFICATION FORM

Date: _____

Time: _____

Last Name: _____ First Name:_____

Preferred Name: _____ Preferred Pronoun: _____

Address: _____
(Street)

_____
(City/Town) **(Province/Country)** **(Postal Code)**

Date of Birth: _____ Age: _____
Day Month Year

Telephone No.: (_____)_____ (_____)_____
(Home) (Business)

Telephone Number (other) _____

E-Mail Address _____

Country of Birth: _____

What is your first language? _____

Emergency Contact: _____ _____
(Name) (Phone Number)

MEDICAL HISTORY

1. How many previous pregnancies have you had? _____.

2. How many children do you have? _____. What are their ages? _____

   Are you presently breastfeeding? Y / N

   Did you have any problems with previous pregnancies? Y / N If yes, what were they_____

3. How many vaginal deliveries have you had? _____

4. Have you had any previous cesarean sections? Y / N If yes, why _____

5. Have you ever had a miscarriage? Y / N If yes, how many _____

6. Have you ever had an ectopic pregnancy (tubal pregnancy)? _____

7. Have you ever had an abortion before? Y / N If yes, where and when _____

8. Have you ever had a pap smear / pelvic exam before? Y / N
   If yes, when was your last pap smear? _____
   Have you ever had an abnormal pap smear? Y / N
   Have you ever had pelvic inflammatory disease or endometriosis? Y / N
   Have you ever had an STI (sexually transmitted infection)? Y / N If yes, was it treated? Y / N

9. Would you like us to test today for Bacterial Vaginosis, Gonorrhea, Chlamydia Y / N
   Would you like a Pap Smear (cervical cancer screening)? Y / N
   Would you like us to test for Syphilis? Y / N
   If yes, provide a phone number or email address where you can be contacted. _____
   You will only be contacted if results are positive.

10. Have you ever had a HPV vaccine? If so when? _____
    Would you like information on that today? Y / N

11. If you are receiving a Depo injection today, when was your last injection? _____

12. Have you ever been admitted to a hospital before? Y / N If yes, what for _____

13. Have you ever had surgery on your Uterus, Fallopian Tubes or Cervix? Y / N
    If yes, what type of surgery? _____

14. Have you ever had or do you have any of the following (please circle)? **None** - Epilepsy – Diabetes – Anemia
    High Blood Pressure – Asthma/Hay Fever – Von Willebrand Disease – Bleeding Problems – Hepatitis – Thyroid
    HIV – AIDS – Inflammatory Disease – Renal – Ulcers and Heart Burn – Rapid / Irregular / Heart Rate – Crohn's
    Ulcerative Colitis – Hyper Emesis – Liver – Immune Thrombocytopenic Purpura – Other _____

15. Have you experienced any of the following? **None** – Depression – Anxiety / Panic Attacks – Bi-Polar
    FASD – ADHD – ADD – Post Partum Depression – Schizophrenia – Anorexia / Bulimia – PTSD

16. Do you have any allergies that you are aware of? Y / N If yes, see below.

Allergy			**REACTION**	**ALLERGY**			**REACTION**
Penicillin	Y	N		Sulfa	Y	N	
Tetracycline	Y	N		Flagyl	Y	N	
Nesacaine	Y	N		Gentamicin	Y	N	
Xylocaine	Y	N		Cipro	Y	N	
Lidocaine	Y	N		Erythromycin	Y	N	
Demerol	Y	N		Advil	Y	N	
Codeine	Y	N		Amoxicillin	Y	N	
Morphine	Y	N		Ampicillin	Y	N	
Tylenol	Y	N		Anaprox	Y	N	
Latex	Y	N		Cytotec	Y	N	
Methotrexate	Y	N		Remifentanil	Y	N	
Fentanyl	Y	N		Versed	Y	N	
Other							

17. Do you have any environmental or food allergies? Y / N Unknown If yes, please list below

_____

18. Are you allergic to anesthesia? Y / N Unknown

19. Do you, or anyone in your family, have malignant hyperthermia (severe over heating of the body generally due to anesthetic)? Y / N Un known

20. Have you, or any close relative, had a venous thrombosis (blood clot in leg, thigh, lung or pelvis)? Y / N Unknown

21. Please list ANY medications or remedies you take on a daily/regular basis: _____

22. DO you have benefits for prescription drugs? Y / N

23. Do you smoke? Y / N

24. Do you use recreational drugs on a regular basis or have you been heavily dependent in the past? Y / N
If yes, please circle: Speed – Cocaine – Crack – Marijuana – Ecstasy – Mescaline – Crystal Meth – LSD Methadone – Heroin – Morphine – Alcohol – Other.
Have you used any in the last 24 hours? Y / N If yes, what _____
how much _____

25. What method of birth control would you like to use in the future? _____
Birth control requested_____ Rx Sample / Quick start

I HEREBY DELCARE THAT I FILLED OUT THIS FORM TO THE BEST OF MY ABILITY

Date: _____ Signature:_____