WOMAN'S HEALTH OPTIONS
(No previous Chart)

IDENTIFICATION FORM

Date: _____

Time: _____

Last Name: _____ First Name:_____

Preferred Name: _____ Pronouns(e.g.: she/her, he/him, they/them):_____

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 _____

What is your first language? _____

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

MEDICAL HISTORY

1. When was the first day of your last menstrual period? _____
   Do you think you could be pregnant Y / N

2. When was the last time you had intercourse and /or engaged in sexual activity? _____

3. How many previous pregnancies have you had? _____

4. How many children do you have? _____

5. Have you had any previous cesarean sections? Y / N

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

7. 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

8. Would you like us to test today for Gonorrhea and Chlamydia Y / N
   Would you like a Pap Smear (cervical cancer screening)? Y / N
   Would you like us to test for Syphilis? Y / N
   Would you like a test for HIV today? Y / N
   If yes, provide an email address where you can be contacted. _____

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

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

11. Do you have any medical conditions? Y / N
    If yes, what _____

12. Do you have any allergies that you are aware of? Y / N
    If yes, what _____
    Are you allergic to any local anesthetic? Y / N

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

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

15. Do you have benefits for prescription drugs? Y / N

16. Do you smoke? Y / N Do you use recreational drugs? Y / N

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

Date: _____ Signature:_____