Wetaskiwin Family Medical Practice

Please complete prior to appointment.

FEMALE

Name: ___________________________

1. First day of last menstrual period or date of last menstrual period if through menopause: ___________________

2. Number of times pregnant: _____

   Number of completed pregnancies: _____

   Date of last pregnancy: ________________________

   If you are under age 55, what method of birth control do you use?_________________________________

   If pills, what kind?____________________________

   How many years have you used the pill? ___________

   Are you planning a pregnancy in the next 6-12 months? **YES** **NO**

3. If you are through menopause or over age 50, do you take any of the following pills?

   Calcium **YES** **NO**

   Estrogen (Premarin) **YES** **NO**

   Progesterone (Provera) **YES** **NO**

4. Have you had any of the following problems:

   a. Abnormal Pap smears **YES** **NO**
      If yes, date: _____________________________
      Problem: ________________________________

   For abnormality, did you have any of the following done:
   Colposcopy **YES** **NO**
   Biopsies **YES** **NO**
   Surgery **YES** **NO**

   b. High blood pressure, heart disease or high cholesterol **YES** **NO**

   c. Migraine headaches, blood clot in legs or cancer **YES** **NO**

   d. Abdominal or pelvic surgery or special tests **YES** **NO**

   If yes, what: ____________________ when: __________

5. Do you have any of the following?

   a. Problems with present method of birth control **YES** **NO**

   b. Bleeding between periods or since periods stopped **YES** **NO**

   c. Pain with intercourse or periods **YES** **NO**

   d. Any problem with interest in or enjoying intercourse **YES** **NO**

   e. A new or enlarging lump in breast **YES** **NO**

   f. Change in size/firmness of stools **YES** **NO**

   g. Change in size/color of a mole **YES** **NO**

   h. Severe headaches **YES** **NO**

   i. Chest pain, shortness of breath, stomach problems or heartburn **YES** **NO**

   j. Sleeping poorly or having any trouble falling or staying Asleep during the past month **YES** **NO**

   k. Bothersome joint pain **YES** **NO**

   l. Problems with falling or doing routine tasks at home **YES** **NO**

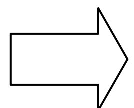
   m. Periods of weakness, numbness or inability to talk **YES** **NO**

   n. Often feeling down, depressed or hopeless during the past month **YES** **NO**

   o. Often having little interest or pleasure in doing things during the past month **YES** **NO**

   p. Conflict in your family or relationships, sometimes handled by pushing, hitting or cruelty **YES** **NO**

Please complete other side



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6. Have you had or do you have a parent, brother or sister with a history of the following:
   a. Cancer of the breast, intestine or female organs **YES** **NO**

   b. Heart pain or heart attacks before the age of 55 **YES** **NO**

   c. Diabetes **YES** **NO**

   If yes to a, b or c:
   Relation: ____________________ Type: _________________
   Relation: ____________________ Type: _________________
   Relation: ____________________ Type: _________________
   Relation: ____________________ Type: _________________

7. Osteoporosis (thin-bone) screening:

   a. Is there a history of any relatives with the following: stooping over or losing height as they got older, "thin bones," hip fractures **YES** **NO**
   If yes, relation: ____

   b. Have you had any of the following:

   Height loss **YES** **NO**
   Broken hip or wrist **YES** **NO**
   Bone-density test **YES** **NO**

   c. Do you take any of the following:
   Steroids (prednisone) **YES** **NO**
   Medication for thyroid, seizures or thin bones **YES** **NO**

8. Have you ever used tobacco? **YES** **NO**
   If yes:
   Average number of packs/day:______
   Number of years smoked:_______
   Year quit:______
   When or are you planning to quit?
   now **next 6 months** **sometime** **never**

9. Do you drink alcohol? **YES** **NO**
   How many drinks per week? ______________________
   Type of Alcohol? ________________________________
   If yes:
   a. Have you ever felt you should cut down on your drinking? **YES** **NO**

   b. Have people ever annoyed you by nagging you about your drinking? **YES** **NO**

   c. Have you ever felt guilty about your drinking? **YES** **NO**

   d. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? **YES** **NO**

10. Do you use street drugs? **YES** **NO**

11. Prevention:
    a. Which of the following are included in your diet:

Grains and starches	**Many**	**Some**	**Few**
Vegetables	**Many**	**Some**	**Few**
Dairy foods	**Many**	**Some**	**Few**
Meats	**Many**	**Some**	**Few**
Sweets	**Many**	**Some**	**Few**

    b. Exercise:
    Activities: ____
    ____
    Days per week: ______________
    Time/duration: _________ minutes
    Exertion: **Stroll** **Mild** **Heavy**

    c. Have you had a tetanus shot in the past 10 years? **YES** **NO**

    d. Have you ever had a mammogram? **YES** **NO**

    If yes, date of last: ________ where:___________________

    Have you ever had any abnormal mammograms? **N/A** **YES** **NO**
    If yes, date: ________ problem: ___________________
    For abnormality, did you have any of the following:

    Biopsy **YES** **NO**
    Cyst fluid drained **YES** **NO**
    Surgery **YES** **NO**

    e. Do you see a dentist regularly? **YES** **NO**

    f. Do you get an influenza shot yearly? **YES** **NO**

12. If you have medical concerns, please list the 3 most urgent:

____
____
____
____
____