Juniper Gynecology & Obstetrics

Surname	Given Names	Date of Birth	Age	Today's Date
Personal Health Number	Home Phone Number	Cell Phone Number	Work Phone Number	
Emergency Contact Name:	Emergency Contact Phone Number:	Relationship to you:		
Address	Email	Pronouns		
Family Doctor/Nurse Practitioner	Referring Doctor/Care Provider			

Obstetric History

How many times have you been pregnant?	Number of miscarriages:	Number of abortions:
Number of ectopic pregnancies:	Complications during pregnancy:	If pregnant, due date:
Delivery of babies - year, and if cesarean or vaginal:	Do you have plans for future fertility?	
	If trying to conceive, how long trying?	

Gynecologic History

Are you currently sexually active? ☐ **Yes** ☐ **No** ☐ **Never have been**	Who do you have sex with? ☐ **Men** ☐ **Women** ☐ **Both**	Do you have pain with sex? ☐ **Always** ☐ **Sometimes** ☐ **Never**
Current birth control (condom, vasectomy, IUD, pill, etc):	Previous birth control methods:	
Have you had any STIs? Type(s)?		
Do you have any history of trauma that may affect your experience with us that you want us to be aware of? ☐ **Yes** (*if yes - see next question*) ☐ **No**	If **Yes**, how can we best make a pelvic exam comfortable for you?	
First day of last menstrual period/year of menopause:	Do you get a monthly period? ☐ **Yes** ☐ **No**	Are periods painful? ☐ **Yes** ☐ **No**
Rate of flow ☐ **Heavy** ☐ **Medium** ☐ **Light**	Days of flow:	Any menopausal symptoms (hot flashes, vaginal dryness, etc):
Date of last Pap:	Past abnormal Paps? ☐ **Yes** ☐ **No**	Prior gynecologic history (hormone therapy, D&C, biopsy, etc):

Social History

Relationship/marital status:	Your occupation:

Continue to next page →

General Medical History

Current or previous medical conditions:

☐ **Heart attack or stroke** ☐ **High blood pressure** ☐ **Blood clotting disorder** ☐ **Lung disease**
☐ **Liver issues** ☐ **Kidney issues** ☐ **Bladder problems** ☐ **Bowel problems** ☐ **Thyroid issues**
☐ **Depression** ☐ **Anxiety** ☐ **Substance use disorder** ☐ **Migraines** ☐ **Diabetes** ☐ **Cancer**
☐ **Other conditions**:

_____

Current medications (include doses):	Surgical history (include year, anesthetic problems):
Preferred pharmacy (name and location):	Allergies (any type):
Medical problems or cancers in family:	

Height:	**Weight:**	Date of last mammogram:	Date of last colonoscopy:	Past abnormal screening?
Alcoholic drinks per week:	Cigarettes per day:	Marijuana use per week:	Other drug use:	

Office Policies

Welcome to our office. We are pleased to be a part of your health care team. Please advise our medical office assistants if you have had any **lab work, ultrasounds, x-rays**, or any other tests relevant to your visit today. Please update us if your family doctor has changed.

We appreciate that schedules change and ask for as much notice as possible if you need to reschedule your appointment with us. Missed appointments delay care for all patients. **Late cancellations** and **missed appointments** may be assessed a fee if we are given less than **2 business days' notice**. This fee is **$100** for a consultation appointment and **$50** for a follow-up appointment.

Please keep your contact information current because it makes it easy for us to contact you in the event of unexpected schedule changes. We can be called to the hospital for emergencies, and if such an event should occur, our staff will do their best to reach you and provide you with the soonest appointment available.

Please be advised that our staff cannot supervise children in the office, so if they do attend with you, they must be in the presence of a responsible adult at all times.

Respectful communication is expected during all clinic interactions between staff, doctors and patients alike. Our office has a zero tolerance policy for abuse of any staff member, and any disrespectful behaviour may result in patients being asked to seek care elsewhere.

Thank you. **Please sign below to indicate that you have read and understood this information, and to certify that the information you have provided on this form is true, accurate and complete.**

Patient signature	Print name	Date YYYY - MM - DD

If you helped someone prepare this form (parent, translator, etc.), please enter your information above.

Preparer name	Relationship to patient