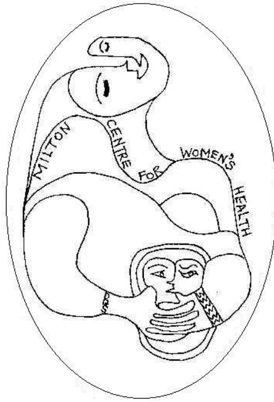


# *Milton Centre for Women's Health*

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## NEW PATIENT INFORMATION

Date ____________________________________

Name ___________________________ Age ______ DOB (YY/MM/DD) ________________

Address _____________________________ City __________________ Postal Code __________

Email Address ____________________________________________________________________

Phone # (Home) __________________ (Cell) _________________ (Work) _________________

Health Card # ____________________________________________ Version Code ____________

Occupation _________________________ Social Status (single, married, etc) _______________

Family Physician ___________________________________________________________________

At what age did you start menstruating? ______________________________________________

How long do your periods last? ________________ frequency? ___________________________

Are your periods irregular, painful or heavy? (please circle all that apply)

When was the start date of your last menstrual period? ___________________________________

Date of last pap smear ___________Result _________ History of Abnormal Pap Smears ______

Please list all pregnancies (if any)

| YEAR | PREGNANCY LOSS/ TERMINATION/DELIVERY | ANY PROBLEMS? |
|---|---|---|
| | | |
| | | |
| | | |

| Please indicate any significant medical problems: | Family history of any significant medical problems: |
|---|---|
| Diabetes | Diabetes |
| High blood pressure | High blood pressure |
| High cholesterol | Heart disease |
| Heart disease | Bleeding or clotting problems |
| Heart murmurs | Genetic disorders |
| Liver disease | Cancer: please specify |
| Bleeding or clotting disorders | |
| Endometriosis | |
| Thyroid | |
| Lung disease | |
| Epilepsy/Neurological | |
| Depression/Anxiety | |
| Cancer: please specify | |
| Other: | |
| Please list any surgeries:<br>____________________<br>____________________<br>____________________ | Do you smoke? _______<br>Amount of alcohol per week?<br>______________________________________ |
| Anaesthetic Complications or Blood Transfusion<br>____________________<br>____________________ | |
| Current Medications (including herbal and vitamin supplements):<br>____________________<br>____________________<br>____________________<br>____________________ | Reason for visit today?<br>____________________<br>____________________<br>____________________<br>____________________<br>____________________ |
| Allergies:<br>____________________<br>____________________<br>____________________<br>____________________ | |