Juniper Gynecology & Obstetrics

215 - 1522 Finlay St. White Rock BC, V4B 4L9

Patient History

Surname	Given names		Date of birth YYYY - MM - DD	Age	Today's date YYYY - MM - DD
Personal Health Number	Home phone .( ) -	Cell phone .( ) -	Work phone .( ) -	Preferred contact number	
Address		Email		Pronouns	
Reason for your visit today		Treatments you've tried for this problem			
Preferred appointment reminder method		Family doctor/NP		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 delivery		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**	Current birth control (condoms, vasectomy, IUD, pills)
Have you had any STIs? Type?	Do you have pain with sex? ☐ **Always** ☐ **Sometimes** ☐ **Never**	Have you ever been physically or sexually harmed? ☐ **Yes** ☐ **No**
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 YYYY - MM - DD	Past abnormal Paps ☐ **Yes** ☐ **No**	Prior gynecologic history (hormone therapy, D&Cs, biopsies, etc.)

Social History

Relationship/marital status	Occupation

***see 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 (include 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
		YYYY - MM - DD	YYYY - MM - DD	☐ **Yes** ☐ **No**
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 possible.

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 below.

Preparer name	Relationship to patient