women's vita
MEDICAL CLINIC

Dr. Ana Teresa Armas Enriquez, MD, CCFP

p. 250 591 9812
f. 250 244 4880
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102-1621 Dufferin Crescent
Nanaimo, BC V9S 5T4

Patient History/Questionnaire (New Patient Registration):

* Please fill out ALL to the best of your ability, the nurse will go over all questions/concerns with you when she brings you into the room before you meet with the doctor *

Patient Name: _____ Gender: _____

Preferred Name: _____ Preferred Pronouns: _____

Maiden/Previous: _____ Date of Birth: _____ Age: _____

CareCard Number: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Home: _____ Cell: _____

Email: _____

Occupation (if retired, please indicate what you did previously): _____

How did you hear about us? _____

Emergency Contact: _____ Phone Number: _____ Relation: _____

Relationship Status:
☐ Single ☐ Married ☐ In a Relationship ☐ Separated ☐ Divorced ☐ Widowed

Do you have other family members who are patients at this clinic?

If so, please list: _____

☐ Children ☐ Spouse ☐ Other: _____

Family Physician (previous or current): _____ City: _____ Clinic Name: _____

Preferred Pharmacy: _____ Preferred Laboratory (for bloodwork): _____

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Reason for Appointment today: (please list all of the things you would like to discuss with the Doctor – if it is more than one problem and we don't have time for all today, we can make the appropriate appointments for follow up to discuss all of your health needs):

_____
_____
_____
_____
_____

Medical History:

Previous Diagnoses (diabetes, hypertension, hypothyroid…etc.):

_____
_____
_____
_____

Medications (please include dose/frequency):

_____
_____
_____
_____

Allergies (with reactions):

_____
_____
_____
_____
_____

Previous Surgeries:

_____
_____
_____
_____
_____

Previous Hospitalizations or Procedures (biopsies, colposcopies, colonoscopy?)

_____
_____
_____
_____
_____
_____
_____
_____

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Family History: Please fill out chart below by placing CHECK for each of your family members…

M= Mother F= Father GM = Grandmother GF= Grandfather U=Uncle A= Aunt B= Brother S= Sister

CONDITION:	MOTHERS SIDE:						FATHERS SIDE:						SIBLINGS:	
	M	**GM**	**GF**	**U**	**A**	**C**	**F**	**GM**	**GF**	**U**	**A**	**C**	**B**	**S**
ALCOHOLISM:														
AUTOIMMUNE DISORDER:														
CANCER – BREAST:														
CANCER – OVARY:														
CANCER – UTERUS:														
CANCER – OTHER:														
HEART DISEASE:														
BLEEDING PROBLEMS:														
BIRTH DEFECTS:														
CONGENITAL HEART PROBLEMS:														
HEART ATTACK:														
DEPRESSION:														
DIABETES:														
HIGH CHOLESTEROL:														
HIGH BLOOD PRESSURE:														
MENTAL ILLNESS:														
OSTEOPOROSIS:														

Additional Details or Comments:

_____

_____

_____

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Social History:

Drugs:
□ Never
□ Ex-User
□ Occasional/Recreational
□ Daily User

What drugs did/do you use? (if applicable):
_____

How often do/did you usually use?
_____

Number of (alcoholic) drinks/week: □ less than 7 □ more than 7 □ less than 14 □ more than 14
Smoking: □ Never □ Quit _____ □ # of cigarettes/day _____

Gynecological History:

First day of Last Menstrual Period: _____
Age of First Period: _____

Current birth control method: _____
Age of Menopause: _____ □ N/A

Menstrual Cycle: □ regular □ irregular Days of Flow: _____ Days between Cycles (average): _____
Flow: □ normal □ light □ heavy Pain: □ mild □ moderate □ severe
Other: □ abnormal vaginal odor □ abnormal vaginal discharge □ abnormal bleeding
□ vaginal itching □ vaginal discomfort

Pap Smear History (Cervical Cancer Screening):
Date of Last Pap: _____
Results: _____
History of Abnormal Paps: □ no □ yes (please list year and result) _____

If applicable, Menopause: Year: _____ Age: _____ Surgical or Natural: _____
Symptoms: □ hot flashes, night sweats, insomnia □ emotional or memory issues □ vaginal dryness □ bleeding

Breast Health: □ breast discharge □ breast lump □ breast pain
Do you perform self-breast exams? □ yes □ no
Prior Breast Surgery: (reconstruction, augmentation, reduction, biopsy, lumpectomy, mastectomy)
_____
Last Mammogram: _____
Additional History:
Urinary: □ incontinence □ urgency □ frequency
Abnormal: □ bleeding □ discharge □ odor □ itching
History of Infertility (describe): _____

Sexual Health:

Age at First Activity: _____
Number of Sexual Partners: _____
Partners: □ male □ female
History of STIs or STDs: _____
Sexual Orientation: _____

Are you currently sexually active? □ yes □ no
Is there any chance that you are currently pregnant?
□ yes □ no
Is sexual activity painful? □ yes □ no
Do you bleed after sex? □ yes □ no

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Obstetric History:

# of Pregnancies: _____ # of Live Births: _____
# of premature births: _____ # of induced abortions: _____
# of miscarriages: _____ # of ectopic pregnancies: _____

Previous Pregnancies: (if you need additional room, please add to additional comments)

Date (year): _____
Hospital: _____
Weeks at Delivery: _____
Name: _____
Weight: _____
Gender: _____
Vaginal or C/S: _____
Complications: _____

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Hospital: _____
Weeks at Delivery: _____
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Gender: _____
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Date (year): _____
Hospital: _____
Weeks at Delivery: _____
Name: _____
Weight: _____
Gender: _____
Vaginal or C/S: _____
Complications: _____

Additional Comments:

_____
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