


WESTCOAST WOMEN'S CLINIC

for Hormone Health



MEDICAL PROFILE QUESTIONNAIRE (<35 yrs)

Date: _____ Name: _____ Phone: _____ Address: _____ E-mail: _____ Occupation: _____ Personal Health Number: _____	Referring M.D.: _____ Family M.D.: _____ Age: _____ Height: _____ BP (Doctor's use): _____ Weight: _____ BMI (Doctor's use): _____ How did you hear about our clinic? _____ <input type="checkbox"/> No <input type="checkbox"/> Yes Would you be interested in hearing about upcoming health seminars/discussion groups that are held by the clinic?
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What are your MAIN CONCERNS (including what you would like to address at this clinic)?

Gynecological history and other background:

Past history of or current:

NO	YES	
<input type="checkbox"/>	<input type="checkbox"/>	STDs - list: _____ Treatment details: _____
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis
<input type="checkbox"/>	<input type="checkbox"/>	Ovarian cysts
<input type="checkbox"/>	<input type="checkbox"/>	Uterine cancer
<input type="checkbox"/>	<input type="checkbox"/>	Fibroids
<input type="checkbox"/>	<input type="checkbox"/>	Colon cancer
<input type="checkbox"/>	<input type="checkbox"/>	Ovarian cancer
<input type="checkbox"/>	<input type="checkbox"/>	Cervical cancer
<input type="checkbox"/>	<input type="checkbox"/>	Cervical dysplasia Treatment details: _____
<input type="checkbox"/>	<input type="checkbox"/>	Breast cancer
<input type="checkbox"/>	<input type="checkbox"/>	Unusual vaginal bleeding Details: _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had a laparoscopy? If so, when? _____ Details: _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had a pelvic ultrasound? If so, when? _____ Details: _____

Date of last menstrual period: _____ (approx. is ok)
 Frequency of periods: _____
 Age at first menstrual period: _____
 Number of pregnancies: _____ Number of children: _____
 Are you trying to become pregnant? No Yes
 Having trouble getting pregnant? No Yes
 Are you sexually active? No Yes
 What is your sexual orientation? _____
 What type of contraception are you using?
 Now: _____
 In the past: _____
 Last pap smear: _____ (date)
 All normal in the past? No Yes
 Details: _____

For office use only:

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Symptoms:

Check off all symptoms that apply and fill in table:

No	Yes	Current Symptom(s)	When did it start?	Frequency/Severity	Details (for office use only)
[]	[]	Adult Acne			
[]	[]	Unexplained weight gain			
[]	[]	Overweight			
[]	[]	Difficulty sleeping			
[]	[]	Mood swings/irritability			
[]	[]	Fatigue/low energy			
[]	[]	Irregular menstrual cycles			
[]	[]	Long (>35 days) cycles			
[]	[]	Decreased sex drive			
[]	[]	Hair loss/thinning (on head)			
[]	[]	Hair growth: upper lip/chin			
[]	[]	breasts			
[]	[]	back			
[]	[]	upper arms/thighs			
[]	[]	PMS			

Have you tried non-prescription remedies to treat your symptoms?
 No Yes (please fill in table):

Have you tried prescription remedies to treat your symptoms (including hormone replacement therapy, spironolactone)?
 No Yes (please fill in table):

Name	How long did you take it? Approx. dates of use?	Was it helpful?	
		Yes	No
		[]	[]
		[]	[]
		[]	[]
		[]	[]

Name and strength	How long did you take it? Approx. dates of use?	Was it helpful?	
		Yes	No
		[]	[]
		[]	[]
		[]	[]
		[]	[]

Additional history (for office use only):

Past Medical History:

Check off all that apply:

- Blood clots
- High blood pressure
- Migraine headaches
- Eating disorder
- Problems with absorbing nutrients or medical conditions/ procedures that affect absorption (e.g. celiac disease, crohn's, gastrectomy)

Please provide details regarding any of the above (if applicable):

Other serious medical conditions: Details: _____

Previous surgeries/procedures: Details and dates: _____

Medication allergies: _____

Describe allergic reaction: _____

Peanut allergies: _____

Current medications:

Are you currently taking prescription medication?

No Yes (please fill in table):

Name and strength	How long have you taken it?

Are you currently taking non-prescription medication or supplements?

No Yes (please fill in table):

Name and strength

For office use only:

For office use only:

Life Style Assessment:

NO YES

Caffeine (tea/coffee/colas) consumption: ___drinks/day

Exercise: ___minutes/hours (circle one) ___times/week

Describe what type of exercise: _____

Meditation/yoga/relaxation techniques: ___times/week

Current smoker: _____cigs/day.

Past smoker

Alcohol consumption ___drinks/day ___drinks/week

Do you have any special dietary habits?

Details: _____

How many hours do you work/week? _____

What times (e.g. 9am-5pm) _____

How many hours of sleep do you get/night? _____

Do you feel rested in the morning? _____

Social history:

Marital status:

- Single Have a boyfriend/girlfriend
- Married/common law Divorced/separated

Living arrangements:

- Live alone Live with partner
- Live with parents Have children at home
- Other: _____

RISK ASSESSMENT

Bone Health:

NO	YES	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problem: Details _____
<input type="checkbox"/>	<input type="checkbox"/>	Long term use of: <input type="checkbox"/> oral steroids (athsma) <input type="checkbox"/> anticonvulsant
<input type="checkbox"/>	<input type="checkbox"/>	Use of Depo-Provera shot
<input type="checkbox"/>	<input type="checkbox"/>	History of eating disorder(s)
<input type="checkbox"/>	<input type="checkbox"/>	Have you had any fractures in the past 10 years? Where? _____
<input type="checkbox"/>	<input type="checkbox"/>	Family history of osteoporosis: Who? _____
<input type="checkbox"/>	<input type="checkbox"/>	Was it treated with medication? _____
<input type="checkbox"/>	<input type="checkbox"/>	Associated with fractures in the hip/spine/wrist? _____

Number of servings of dairy: _____/day. Describe your dietary sources of calcium: _____

Calcium supplement: _____ (mg elemental/day).
How often? _____ With food? No Yes

Vitamin D: _____ (IU/day).

Does Osteoporosis concern you? No A little Moderately
 A lot

For office use only:

Risk factors:

- Caucasian/Asian
- Positive family history
- Smoker
- Inadequate calcium intake
- Slender frame
- Postmenopausal
- Sedentary lifestyle
- Increased alcohol intake
- Increased caffeine intake
- Minimal or no risk factors identified

Breast Health:

NO	YES	
<input type="checkbox"/>	<input type="checkbox"/>	Do you examine your own breasts: how often? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a breast lump biopsy? When? _____
<input type="checkbox"/>	<input type="checkbox"/>	History of previous breast cancer: When? _____ Age? _____
<input type="checkbox"/>	<input type="checkbox"/>	Family history of breast cancer: Who? _____ Age? _____

BMI (doctor's use): _____

For office use only:

Risk factors:

- Obesity
- Positive family history
- Sedentary lifestyle
- Increased alcohol intake
- HRT >5 years
- Personal history of breast cancer
- Nulliparous
- Minimal or no risk factors identified

Heart Health:

NO YES

- High cholesterol: last measured: _____
Results (if known): _____
- High blood pressure: last measured: _____
Results (if known): _____
- Diabetes (insulin No Yes)
- Family history of heart disease: Who and describe nature: _____
- Do you eat more vegetables than meat?

For office use only:

Risk factors:

- Obesity
- Smoker
- HTN
- Hyperlipidemia
- Pre-existing heart disease
- Diabetes
- Sedentary lifestyle
- Positive family history
- Minimal or no risk factors identified

Diabetes:

NO YES

- Have you had your blood sugar tested?
Last measured: _____
Results (if known): _____
- Do you have high blood sugar/diabetes?
- Do you have a family history of diabetes?
Who? _____
- History of diabetes with pregnancy: _____

For office use only:

Risk factors:

- Obesity
- Positive family history
- Sedentary lifestyle
- History of gestational diabetes
- Minimal or no risk factors identified

Emotional Wellness:

NO YES

- Do you have/feel:
- stressors in your life right now
- depressed, sad or down most of the time
- diminished interest or pleasure most of the time
- significant changes in weight (gain or loss)
- lack of sleep or too much sleep
- tired most of the time
- feelings of worthlessness or excessive guilt or hopelessness
- reduced ability to think or concentrate, or are indecisive most of the time
- diminished interest in sexual activities
- past history of depression
- past history of post partum depression
- history of depression in your family
- Who? _____

For office use only:

Risk factors:

- Personal history of depression
- Family history of depression
- Current stressor
- Other: _____
- Minimal or no risk factors identified

Please provide details regarding any of the above (if applicable):
