CENTRE DE SANTÉ DES FEMMES DE MONTRÉAL
Health Check and Gynecological Profile

HEALTH/GYNECO

DATE	AGE

FIRST AND LAST NAME or RAMQ card

HEALTH CHECK

Do you take any medication? ☐ Yes ☐ No
If so, specify which:

Do you have any known allergies? ☐ Yes ☐ No
If so, specify which:

Do you smoke cigarettes? ☐ Yes ☐ No If so, specify how many cigarettes per day:

Do you currently have or have you ever had gynecological problems (ex: pain during intercourse, ovarian cysts, uterine fibroids, vaginal infection, infection of the uterus, colposcopy)?
☐ Yes ☐ No If so, specify which:

Do you have any health problems?
☐ High blood pressure ☐ Blood clots in the legs ☐ Liver disease
☐ Heart disease ☐ Diabetes ☐ Cancer ☐ Migraines
☐ Others - Specify:

Have you ever been hospitalized/had surgery?
☐ Yes ☐ No If so, specify:

Are there any specific health problems in your family (ex: breast cancer, clotting problem)? ☐ Yes ☐ No
If so, specify the health problem and the relationship:

GYNECOLOGICAL PROFILE

Date of the last normal menstrual period (1st day)	Date of your last Pap test (cytology, smear)?

Have you ever been screened for sexually transmitted infections? ☐ Yes ☐ No
If so, indicate the date:

Avec you ever had any sexually transmitted infections? ☐ Yes ☐ No
If so, specify the type of infection (gonorrea, chlamydia, herpes, etc.) and year:

Do you use a contraceptive method? ☐ Yes ☐ No If so, specify which:

Have you ever suffered from unwanted side effects from your contraceptive method? ☐ Yes ☐ No
If so, specify which ones and their side effects:

Have you ever been pregnant? ☐ Yes ☐ No If so, specify the following information:

Number of vaginal births _____
Number of caesarean sections _____
Number of miscarriages or abortions _____

DOCTOR'S SIGNATURE

NOTES

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