BONNYVILLE MEDICAL CLINIC

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Website: bonnyvillemedicalclinic.ca

**NAME:** _____ **Best Contact Phone #:** _____

## WELL WOMAN CLINIC QUESTIONNAIRE

1. When was your last period (approximately)? _____
2. Describe your periods
   a. How often do they occur? _____
   b. How long do they last? _____
   c. Describe the flow _____
3. How many pregnancies have you had? _____
4. How many live births have you had? _____
5. Are you sexually active? _____ Yes _____ No
   a. If yes, what are you using for birth control? _____
6. When was your last PAP smear (approximately)? _____
7. Have your PAPs always been normal? _____ Yes _____ No
   a. If no, what treatment or follow-up did you have?

   _____
8. Do you wish to have STI screening done today? Yes _____ No _____
   a. If so circle what type of screening:
   Gonorrhea / Chlamydia / HIV / HepC / Syphilis
9. Do you have problems with bladder control? _____
10. Have you ever been investigated for breast lumps? _____
11. When was your last mammogram (approximately)? _____
12. Does anybody in your immediate family have breast cancer? _____
13. Do you have any other gynaecological concerns? _____
14. Please list any allergies _____
15. Please list your medications / vitamins / supplements _____