



WESTCOAST WOMEN'S CLINIC  
for Midlife Health

MEDICAL PROFILE

|                               |   |
|-------------------------------|---|
| Date: _____                   | Referring M.D.: _____   |
| Name: _____                   | Family M.D.: _____  |
| Phone: _____                  | Age: _____  |
| Address: _____                | Height: _____ BP (Doctor's use): _____  |
| E-mail: _____                 | Weight: _____ BMI (Doctor's use): _____   |
| Occupation: _____             | How did you hear about our clinic? _____  |
| Personal Health Number: _____ | <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? |

What are your MAIN CONCERNS (including what you would like to address at this clinic)?

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|  |   |
|--|---|
| <p><b>Gynecological history and other background:</b></p> <p>NO YES</p> <p><input type="checkbox"/> <input type="checkbox"/> Hysterectomy: When? _____ Reason: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Ovaries are: <input type="checkbox"/> intact <input type="checkbox"/> removed: Reason: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Unusual vaginal bleeding: Details: _____</p> <p>Past history of:</p> <p><input type="checkbox"/> <input type="checkbox"/> Endometriosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Ovarian cysts</p> <p><input type="checkbox"/> <input type="checkbox"/> Uterine cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Fibroids</p> <p><input type="checkbox"/> <input type="checkbox"/> Colon cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Ovarian cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Cervical cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Breast cancer</p> | <p>Date of last menstrual period: _____ (approx. is ok)</p> <p>Frequency of periods: _____</p> <p>Age at first menstrual period: _____</p> <p>Number of pregnancies: _____ Number of children: _____</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Are you sexually active?</p> <p>What is your sexual orientation? _____</p> <p>What type of contraception are you using?</p> <p>Now: _____</p> <p>In the past: _____</p> <p>Last pap smear: _____ (date)</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes All normal in the past?</p> <p>Details _____</p> <p>Last mammogram: _____ (date)</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes All normal in the past?</p> <p>Details _____</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Have you had a bone mineral density test or heel ultrasound?</p> <p>When? _____ Results: _____</p> |
| <p>For office use only:</p>  | <p>For office use only:</p>   |

**Menopausal/Peri-menopausal symptoms (skip to the next section if the following does not apply)**

Check off all symptoms that apply and fill in table:

| No  | Yes | Current Symptom(s)       | When did it start? | Frequency | Details (for office use only) |
|-----|-----|--------------------------|--------------------|-----------|-------------------------------|
| [ ] | [ ] | Hot flashes              |                    |           |                               |
| [ ] | [ ] | Night sweats             |                    |           |                               |
| [ ] | [ ] | Difficulty sleeping      |                    |           |                               |
| [ ] | [ ] | Mood swings/irritability |                    |           |                               |
| [ ] | [ ] | Fatigue/low energy       |                    |           |                               |
| [ ] | [ ] | Vaginal dryness          |                    |           |                               |
| [ ] | [ ] | Painful intercourse      |                    |           |                               |
| [ ] | [ ] | Decreased sex drive      |                    |           |                               |
| [ ] | [ ] | Memory problems          |                    |           |                               |
| [ ] | [ ] | Headaches                |                    |           |                               |
| [ ] | [ ] | Heart racing             |                    |           |                               |
| [ ] | [ ] | Aching muscles/joints    |                    |           |                               |
| [ ] | [ ] | Weight gain              |                    |           |                               |
| [ ] | [ ] | Loss of bladder control  |                    |           |                               |
| [ ] | [ ] | Breast tenderness        |                    |           |                               |

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)?

No  Yes (please fill in table):

| Name | How long did you take it?<br>Approx. dates of use? | Was it helpful? |     |
|------|--|-----------------|-----|
|      |  | Yes             | No  |
|      |  | [ ]             | [ ] |
|      |  | [ ]             | [ ] |
|      |  | [ ]             | [ ] |
|      |  | [ ]             | [ ] |

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

What are your personal beliefs about hormone replacement therapy? \_\_\_\_\_

Additional history (for office use only):

**Past Medical History:**

Check off all that apply:

|  |   |
|--|---|
| <input type="checkbox"/> Kidney disease  | <input type="checkbox"/> Liver disease                        |
| <input type="checkbox"/> Gallbladder disease   | <input type="checkbox"/> Stroke or transient ischemic attacks |
| <input type="checkbox"/> Blood clots   | <input type="checkbox"/> Previous heart attack                |
| <input type="checkbox"/> Heart disease   | <input type="checkbox"/> Eating disorder                      |
| <input type="checkbox"/> Rheumatoid arthritis  | <input type="checkbox"/> Migraine headaches                   |
| <input type="checkbox"/> 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:

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**Life Style Assessment:**

|                          |                          |  |
|--------------------------|--------------------------|--|
| NO                       | YES                      |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Caffeine (tea/coffee/colas) consumption: ___drinks/day   |
| <input type="checkbox"/> | <input type="checkbox"/> | Exercise: ___minutes/hours (circle one)___times/week<br>Describe what type of exercises: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Meditation/yoga/relaxation techniques: _____times/week   |
| <input type="checkbox"/> | <input type="checkbox"/> | Current smoker: _____cigs/day.   |
| <input type="checkbox"/> | <input type="checkbox"/> | Past smoker  |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol consumption ___drinks/day ___drinks/week   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any special dietary habits?<br>Details: _____                                      |

**Social history:**

Marital status:  
 Single  Married/common law  Divorced/separated

Living arrangements:  
 Live alone  Live with partner  
 Have children at home  Other: \_\_\_\_\_



**Heart Disease Risk Factors:**

NO YES

- High cholesterol: last measured: \_\_\_\_\_  
Results (if known): \_\_\_\_\_
- High blood pressure: last measured: \_\_\_\_\_  
Results (if known): \_\_\_\_\_
- History of heart disease (examples: angina, heart attack, heart surgery, angioplasty): Details: \_\_\_\_\_  
\_\_\_\_\_
- 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:

- Postmenopausal
- 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? \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

**For office use only:**

Risk factors:

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