DR. Christopher Cham MD, FRCSC
Obstetrics And Gynaecology

Central Alberta Professional Center
Suite 200, 5201 - 43rd Street, Red Deer, AB T4N-1C7
Tel: **(403) 967 – 0170** • Fax: (403) 986 - 0418

New Patient Information Form

Name: _____ Date of Birth: _____ Age: _____

Email Address: _____

Current Family Doctor's Name: _____

Height: _____ Weight: _____ ☐ lbs ☐ kg

In your own words, please tell us why you are coming to the office:

Health Information: Please fill out what applies to you

How old were you when your **periods first started**? _____

How were they as a teenager? ☐ Normal ☐ Heavy ☐ Painful ☐ Regular/Irregular ☐ Missed school

First day of last period: _____

Do you get **premenstrual symptoms** (PMS)? ☐ YES ☐ NO

Do you have **cramps/pain** with your periods? ☐ YES ☐ NO ☐ Sometimes

Do you require **medication** for your periods? ☐ YES ☐ NO ☐ Please List: _____

Please tell us about each of your **PREGNANCIES** (if any), including miscarriages:

Date	Place	Vaginal, C-Section, miscarriage, etc.	Complications	Baby weight at birth

When was your **last Pap test**? _____

Have you had any **abnormal** Paps in the past? ☐ YES ☐ NO

Have you had **HPV vaccinations**? ☐ School ☐ Self Pay ☐ NO

How many did you receive? ☐ 1 ☐ 2 ☐ 3 ☐ Other:

Age of **menopause**: _____

Have you used **hormone replacement** before: ☐ YES ☐ NO If so, When? _____

What are you currently using for **birth control**?

☐ Tubes tied/Vasectomy ☐ Condoms ☐ Withdrawal ☐ Natural (timed intercourse) ☐ Birth Control Pills

☐ Patch ☐ Vaginal ring ☐ Needle (Depo-Provera) ☐ Oher: _____

Have you had any of the following **infections**:

☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Genital warts

☐ HIV ☐ Hepatitis B or C ☐ Chancre ☐ Syphilis

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Do you have major problems with **acne** (pimples, zits)?	☐ YES	☐ NO	☐ Just a little
Do you have major problems with facial **hair** growth?	☐ YES	☐ NO	☐ Just a little
Do you have troubles with **hot flashes** or sweats?	☐ YES	☐ NO	☐ Just a little
Do you have troubles with vaginal **dryness**?	☐ YES	☐ NO	☐ Just a little
Are you currently sexually active?	☐ YES	☐ NO	☐ Just a little
Is/Are your partner(s):	☐ Male	☐ Female	☐ Both
Do you have troubles with intercourse (sex)?	☐ YES	☐ NO	☐ Just a little
Do you experience pain with intercourse (sex)?	☐ YES	☐ NO	☐ Occasionally

Please list all **SURGERIES/OPERATIONS** you have had:

Procedure	Date	Reason

Please list all ongoing **MEDICAL PROBLEMS** you may have:

Name	How long	Notes

Please list all your **MEDICATIONS**:

Name	Dose	Why you take it

Please list all of your **ALLERGIES**: _____

Are there any medical problems that run in your **FAMILY**? ☐ YES ☐ NO

Describe the family medical problems: _____

Do you smoke cigarettes? ☐ YES ☐ NO ☐ If so, how much? _____

Do you vape? ☐ YES ☐ NO ☐ If so, how much? _____

Do you use marijuana/THC? ☐ YES ☐ NO ☐ If so, how much? _____