Patient Label

Welcome to the Women's Health Clinic at Seton Medical Clinic

Patient Agreement and Registration

Please read and sign the following regarding the scope of this clinic.

- I provide Women's Health consultations for common women's screening and concerns.
- I provide PAP tests to screen for Cervical Cancer according to the ACTT (Accelerating Change Transformation Team) of Alberta.
- I provide testing and information for Sexually Transmitted Illness (STIs).
- I provide contraception counseling, including management of IUDs and Implanted Contraception (Nexplanon).
- I provide early prenatal care until you are transferred to the appropriate prenatal care group.
- I provide breast health consultations and address any concerns. I follow the screening guidelines of ACTT (Accelerating Change Transformation Team) of Alberta.
- I provide consultation for any menstruation concerns and management recommendations.

It is important that I have information about your medical history before any procedures or medical advice. Please help by completing the short questionnaire.

Please note: The clinic is not a referral service; patients must return to family physicians for specialist referrals. It is important to recognize that you should create or maintain your current relationship with a family physician in the community. If you do not have a family physician, you can search for physician taking new patients at https://albertafindadoctor.ca/.

I, ____________________________, agree with the terms of the patient agreement.
(please print name)

Signature: ______________________________ Date: _________________________

 v. Dec 30/22

Patient Label

Registration information

(circle choices)

Family Physician:

None / Name: ________________________

Who sent you to our clinic?

Family Doctor / Another Medical Clinic / Self referred

With which cultural group do you identify?

North American / Aboriginal / Hispanic / American / Other__________________

MEDICAL HISTORY

1. When was your last PAP test?

Never / <1 year ago / 1-3 years ago / 4-5 years ago / >5 years / This is my first PAP

2. Have you ever had an abnormal PAP test result? Yes / No

3. First day of last menstrual period? _____________ Cycle every _______days

4. Number of pregnancies? ______ Are you pregnant now? Yes / No

5. Circle the contraceptive methods you currently use:

None IUD Implant Pill Patch Condoms

Diaphragm Ring Depo-provera Tubal Ligation/surgery

Are you happy with your current method? Yes / No

6. Have you had any previous gynecological problems? Yes / No

If yes, (eg, fibroids, hysterectomy) ____

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7. Have you had an HPV vaccine (e.g.Gardasil) No / Yes # of doses (1, 2 or 3) ____

8. Family History (parents/grandparents/aunts/uncles/cousins/children):

Breast Cancer   Blood Clots (thrombosis, DVT, PE/pulmonary embolus)

Ovarian or Colon Cancer   I do not know my family history

9. Smoking History: Do you currently smoke? Yes / No

10. Please list any Medical Conditions you are being treated for.

None / ____

11.Current Medications:

none / ____

12.Medication Allergies:

none / ____

THANK YOU FOR TAKING THE TIME TO DO THIS QUESTIONNAIRE. ☺