

**Leslie K. Po, MD MSc FRCSC**

 Obstetrician & Gynecologist

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**Please take a few minutes to answer the following questions prior to your appointment with Dr. Po. You will have the chance to clarify any of the questions once you meet with the doctor. This will hopefully make your appointment more efficient and focused.**

**Name:**

**Date of Birth**:

1. When was the first day of your last period?

2. Have you been pregnant in the past? [ ] Yes [ ] No

 **If Yes, answer the following:**

 How many total pregnancies have you had?

Please list if any of these pregnancies were miscarriages, therapeutic abortions, ectopic pregnancies and indicate the year:

Did you have any vaginal deliveries or C-Sections? Please indicate what year you delivered.

3. Do you have any medical conditions or previous admissions to the hospital? Please list.

4. Have you had any surgeries in the past? Please list and indicate the year the surgery was done.

5. Are you taking any regular medications? **[ ]** Yes [ ] No

 **If Yes, please list:**

6. Do you have allergies to medications? **[ ]** Yes [ ] No

 **If Yes, please list:**

7. Do you have a family history of breast, ovarian, uterine or colorectal cancer? [ ] Yes [ ] No

**If Yes, please provide details:**

8. Do you have a family history of blood clots in the legs or lungs? [ ] Yes [ ] No

**If Yes, please provide details:**

9. Do you smoke cigarettes? [ ] Yes [ ] No **If yes,** how many per day?

10. Do you use cannabis? [ ] Yes [ ] No

11. How many glasses of alcohol do you drink in one week?

12. Do you use recreational drugs? [ ] Yes [ ] No **If Yes,** what and how much per week?

13. Are you currently in a relationship? [ ] Yes [ ] No Are you currently sexually active? [ ] Yes [ ] No

 **If Yes**, what are you using for contraception?

14. What do you do for work?

15. When was your last pap test done?

16. Have you had any abnormal pap tests? [ ] Yes [ ] No

**If Yes**, what and when?

17. Have you ever been treated for a sexually transmitted infection? [ ] Yes [ ] No

**If Yes**, what and when?

18. Are you period regular? [ ] Yes [ ] No

How many days apart are your periods from the first day of one to the first day of the next?

How many days do your periods last?

Are your periods heavy? [ ] Yes [ ] No **If Yes,** how many days are heavy?

On the heaviest day, how often do you change your pad or tampon?

Do you notice clots when you bleed? [ ] Yes [ ] No

Do you experience irregular bleeding between periods? [ ] Yes [ ] No

19. Do you experience pain with your periods? [ ] Yes [ ] No

Rate your pain on a scale of 1 to 10 (1 = no pain, 10 = excruciating pain)

When do you experience pain relative to your period and for how long?

20. Do you have pain with intercourse? [ ] Yes [ ] No

21. Do you experience pain with bowel movements? [ ] Yes [ ] No

 Do you have blood in your bowel movements? [ ] Yes [ ] No

22. Do you have pain with urination? [ ] Yes [ ] No

 Do you have blood in your urine? [ ] Yes [ ] No

***Thank you for completing this form!***