EMPOWERED PAP INTAKE FORM

PERSONAL INFORMATION

Name: ____ Today's Date_____________

Date of Birth:___________________(d/m/y) Age:_______ Gender: M ☐ F ☐ Non-binary/Other ☐

AB Health Care #: ______________

Home Address:____________________________________ _________________

City: ____________________________ Prov: ________ Postal Code:_____________________

Phone (home):_________________________ Phone (cell):____________________

What is the best number to reach you at?________________ Can a message be left at this number? ___

E mail Address: _________________________ Occupation: ____________full time ☐ part time ☐

Ethnicity: __________________________ *(for genetic health risk assessment purposes only)*

Emergency Contact: __________________________________ Relation:___________________

Phone: ______________

I consent to receiving free ongoing support and guidance via email to help me achieve better results in my health: Yes ☐ No ☐

How did you hear about Dr. Candace?

Dr. Candace's website ☐ Clinic website ☐ Referral/Recommended ☐ Internet reviews ☐

Facebook ☐ Instagram ☐ Other Social Media ☐ Other ☐ (please specify):_________

GYNECOLOGICAL HISTORY

Date of Last pelvic exam/ PAP Exam: _________ Results of previous PAP: _________

History of Abnormal PAP(s) Yes ☐ No ☐ If yes, please describe: _____________________

Have you tested positive for HPV? Yes ☐ No ☐ If yes, please describe: _________

☐ History of a Sexually Transmitted Disease (Which, Date and Treatment):

____

____

Are you sexually active? Yes ☐ No ☐

If so, do you use birth control? Yes ☐ No ☐ If yes, what type and for how long?

____

Age at 1st Period: ___________
Duration of Period (Days): ___________
Duration of One Cycle (From first day of period until the start of the next period): ___________
Date of Last Period: ___________
Period: Heavy ☐ Light ☐ Clots ☐

☐ Irregular Periods
☐ Changes in body or emotions prior to or during menstruation (Describe) (ex. Irritability, depression, emotional, anxiety, food cravings, water retention, breast tenderness, bloating, headaches, fatigue):
____
____
____
☐ Bleeding Between Periods
☐ Vaginal Discharge
☐ Vaginal Sores
☐ Breast Lumps
☐ Breast Tenderness
☐ Nipple Discharge
☐ Sexual Difficulties
☐ Low Libido

If you have any of the following now, or have had in the past, please check and explain (including dates):

☐ Low back pain
____
☐ Painful periods / PMS
____
☐ Pain during sex
____
☐ Pelvic / Abdominal pain
____
☐ Prolonged bleeding / Irregular menstrual cycles
____
☐ Fibroids / Ovarian Cysts
____
☐ Constipation / Irritable bowel
____
☐ Hemorrhoids
____
☐ Urinary tract infection / Bladder infections / Yeast or other Vaginal Infections
____
☐ Tearing with birth
____
☐ Childbirth complications
____
☐ Depression / Anxiety
____

- [ ] Drug / Substance abuse
____
- [ ] Eating disorder
____
- [ ] Sexual abuse
____
- [ ] Physical/other abuse
____
- [ ] Cancer
____
- [ ] Smoking
____
- [ ] Other relevant information
____

Are you pregnant? Yes ☐ No ☐ Maybe ☐ Are you currently breast feeding? Yes ☐ No ☐
Are you trying to conceive? Yes ☐ No ☐
Number of Pregnancies_________, Number of Live Births ________, Date and Type of deliveries (vaginal or caesarean)____
Number of Miscarriages _________, Abortions_________

Please list any pelvic or abdominal surgeries (include dates)
____
____

Do you practice regular Self Breast Exams? Yes ☐ No ☐ How Often? ____________________
Date of Last Mammogram: ____________

GENITO-URINARY

☐ Frequent Urination	☐ Inability to Hold Urine	☐ Kidney Stones
☐ Urinary Urgency	☐ Decreased Urine Flow	☐ Other Issues? _________
☐ Pain on Urination	☐ Distinctive Color	
☐ Waking to Urinate	☐ Blood in Urine	

CURRENT HEALTH HISTORY

Do you have any **allergies** to medications, foods, animals, other? If so, please list.

____

____

____

Please list all **medications** you are currently taking, including dosage:

____

____

____

____

Please list all **supplements**, herbs, vitamins or homeopathic medicines you are taking:

____

____

____

____

____

CONSENT FORM

PLEASE NOTE THAT THIS FORM MUST BE READ AND SIGNED PRIOR TO YOUR APPOINTMENT

What is a PAP test?

A PAP test or smear is a screening test that checks the cells of the cervix to ensure no abnormal changes. Abnormal cells can change over time and become cancer.

Your Naturopathic Doctor will take a sample of cells from your cervix. This involves inserting a speculum into your vagina to view the cervix and then using a small broom to collect cells from the cervix itself.

What are the benefits of cervical screening? What are the limitations?

Benefits

- 90% of cervical cancer can be prevented by having regular pap tests.
- It can detect abnormal cell changes in the cervix at an earlier stage when they are easier to treat.

Limitations

- Cervical screening will not prevent all cases of cervical cancer. Some women will still develop cervical cancer despite regular screening. Some abnormal cell changes may still be missed.

Are all abnormal cells found?

Unfortunately, no. A pap test can miss abnormal cell changes.

What causes laboratory error?

Sometimes abnormal cells are missed because they do not look very different from normal cells, there may be very few abnormal cells in the sample or the laboratory technician reading your sample may miss the abnormality.

What should I do?

After your first pap test, plan to have a repeat test every three years. Be sure to inform your healthcare provider if you experience any changes, such as abnormal bleeding between periods, after sexual intercourse or after menopause.

What is reflexive HPV testing?

If you are 30 years old or older and the lab sees cell changes in your pap test that are difficult to interpret, your pap test sample will be **automatically** tested for Human Papillomavirus (HPV) – the main cause of cervical cancer. When women in this age group have high-risk HPV, their infections are more likely to last longer and cause serious cell changes.

References

Cervical Cancer Screening. 2019. Alberta Health Services Cancer Screening Programs. http://screeningforlife.ca/cervical-cancer-at-a-glance/

PATIENT CONSENT (PLEASE INITIAL)
______ I HAVE READ ALL OF THE ABOVE and any questions were discussed with my ND and answered to my satisfaction.

I UNDERSTAND THAT MY IDENTITY WILL BE PROTECTED AT ALL TIMES, AND THAT A HEALTH RECORD WILL BE KEPT DETAILING HEALTH SERVICES PROVIDED TO ME. THIS RECORD WILL BE KEPT CONFIDENTIAL AND WILL ONLY BE RELEASED UNDER MY SPECIFIC DIRECTION OR AS REQUIRED BY LAW. I UNDERSTAND THAT I MAY SEE MY MEDICAL RECORD AT ANY TIME DURING REGULAR BUSINESS HOURS AND THAT A COPY CAN BE REQUESTED FOR A FEE.

By signing below, I consent to evaluation and/or treatment of my condition. I understand the nature and the purpose of the procedures, evaluation, and course of treatment. I have been given the opportunity to ask questions, and my questions have been answered to my satisfaction. I certify that I have read, fully understand, and agree to the terms of this consent form.

PATIENT NAME: (PLEASE PRINT) ____

DATE: ______________________________

SIGNATURE OF PATIENT: ____