

Welcome to the South Calgary PAP Clinic

Patient Agreement and Consent

A patient agreement is a statement of understanding between the person seeking health services and the health professionals at the South Calgary PAP Clinic. Carefully read and sign this patient agreement.

We are a **screening and prevention** clinic and follow current Alberta guidelines.

We provide PAP tests to screen for **cervix cancer**. If you require STI testing at the time of your PAP test, please inform the physician. (We will review your contraception choices with you at your request.)

As per the Alberta Cancer Board, we encourage all women to be “breast aware”. We will be happy to book an appointment for you to review your **breast health** and exam.

We participate in Alberta's New **Colorectal Cancer** screening program for patients age 50-74.

It is a mandate of our clinic to provide **education** in the areas of cervix cancer screening and prevention and in breast health.

It is necessary for the doctors and nurses to enquire about your medical history before any procedures at our clinic. 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. The clinic cannot become your family physician or primary care provider. The physicians at the clinic are **NOT** accepting patients into their practice and thus **it is important to recognize that you should create or maintain your current relationship with a family physician in the community**

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

Signature: _____

Date: _____

Sincerely,
The Physicians of the South Calgary PAP Clinic

PAP CLINIC REGISTRATION

Name: _____
Surname Given Middle

Date of Birth: _____
(dd/month/yyyy)

Alberta Healthcare #: _____
(if not Alberta Health care, please speak to reception)

Family Physician: None
 Name: _____
Location: _____
Family Physician's Gender: Male Female

Would you like us to send your doctor a copy of your results? Yes No

Have you been seen previously at our clinic? Yes No

Who sent you to our clinic:

Family Doctor Another Medical Clinic Agency
 I choose this clinic myself

Have you recently moved to Calgary (within in the past 5 years)? Yes No

With which cultural group do you identify?

North American Native American (Aboriginal) Hispanic American
 Other

MEDICAL HISTORY

1. When was your last PAP test:

- Less than 1 year ago 1-3 years ago 3-5 years ago More than 5 years
 This is my first PAP test

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

3. Pregnancies:

Date of last menstrual period: _____ Are you pregnant now? Yes No

Have you ever been pregnant: Yes No Number of pregnancies: _____

4. Check the contraceptive methods you currently use:

- None Patch Diaphragm Depo Tubal ligation/surgery
 Pill Rhythm Ring Condoms IUD

Are you happy with your current method? Yes No

5. Have you had any previous gynecological problems? Yes No

If yes, _____

eg: fibroids, endometriosis, infertility

6. Have you had an HPV vaccine (Gardasil/Cervarix)?

- No Yes all three Two of Three One only

7. Family History (parents/grandparents/aunts/uncles/cousin/children):

- Breast Cancer Blood Clots (thrombosis, DVT, pulmonary embolus)
 Ovarian or Colon Cancer I do not know my family history (adopted)

8. Smoking History:

Do you currently smoke? Yes No

9. Are you being treated for any medical problem(s)? Please explain:

10. Current Medications (including birth control pill) Please list:

11. Medication Allergies

Please explain reaction:
