The Women's Clinic of Northern Colorado

Fort Collins
1107 South Lemay Ave
Suite 300
Fort Collins, CO 80524
Phone: (970) 493-7442

Loveland
2500 Rocky Mountain Ave.
North Medical Office Building, Suite 150
Loveland, CO 80538
Phone: (970) 493-7442

New Patient Intake Form

DEMOGRAPHIC AND CONTACT INFORMATION

Patient Name_____ Date of Birth____/_____/_____ Age_____ Gender: _____

Primary Language_____ Race_____ Ethnicity_____

Cell Phone _____ Home Phone _____ Work Phone _____

Email Address_____

Primary Care Physician_____ Emergency Contact_____

Local Pharmacy_____ Emergency Phone _____

Mail Order Pharmacy_____ Relationship_____

REASON FOR YOUR VISIT: _____

MEDICAL HISTORY

Medical Conditions and Medications:

Have you been diagnosed with? ☐ High Blood Pressure ☐ Diabetes ☐ Heart Disease

Year or Age Diagnosed	Condition	Medication Name	Dose / Frequency	Doctor/Clinic Managing	Comments/Complications

List any Additional Medications Over The Counter Medications or Supplements: (include dose/frequency)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional space needed?
Check here and finish on last page ☐

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ALLERGIES (List your current allergies, with reactions): ☐ Latex Allergy

_____ _____ _____

_____ _____ _____

PREVIOUS PREGNANCIES:

Date	Hospital	Provider	Weeks	Name	Weight	Gender	Vaginal or C/S	Complications

PAST SURGERIES:

Year/Age	Hospital	Surgeon	Reason for Surgery	Type of Surgery	Complications

HOSPITALIZATIONS OR PROCEDURES (biopsies, colposcopies, colonoscopy, EGD, etc):

Year/Age	Location	Provider	Reason for Procedure	Type of Procedure	Comments/Outcome

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FAMILY HISTORY:

Mother: Age ____ Living ☐ Deceased ☐ **Father:** Age ____ Living ☐ Deceased ☐

Please fill out the chart below by placing an CHECK for each of your family members. .

M=mother F=father GM=Grandmother GF=Grandfather U= Uncle A= Aunt S=sister B=brother C=cousin

CONDITION	MOTHER'S SIDE						FATHER'S SIDE						SIBLINGS	
	M	GM	GF	U	A	C	F	GM	GF	U	A	C	B	S
ALCOHOLISM														
ASTHMA														
AUTOMIMMUNE DISORDER														
CANCER – BREAST														
CANCER – OVARY														
CANCER – UTERUS														
CANCER – COLON														
CANCER - OTHER														
HEART DISEASE														
BLEEDING PROBLEMS														
BIRTH DEFECTS														
CONGENITAL HEART PROBLEMS														
HEART ATTACK														
DEPRESSION														
DIABETES														
HIGH CHOLESTEROL														
HIGH BLOOD PRESSURE														
MENTAL ILLNESS														
OSTEOPOROSIS														

Additional Details or Comments:

_____

_____

_____

Additional space needed?
Check here and finish on last page ☐

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SOCIAL HISTORY:

If you use any of the following, please check off and describe your average use:

Tobacco: ☐ Yes No ☐ cigarettes ☐ other ☐ amount per day: _____

Alcohol: ☐ Yes No ☐ drinks per day: _____ drinks per week: _____

Recreational drugs: ☐ Yes or No ☐ substances: _____ amount per day: _____

Diet and Supplements:

Do you have a Calcium intake of 1200 mg per day? ☐ Yes No ☐

Do you take a Vitamin D supplement on a regular basis? ☐ Yes No ☐

Any type of special diet (Gluten free, vegan, vegetarian, etc)? Describe: _____

Exercise: ☐ Sedentary ☐ Moderate ☐ Vigorous

Types of exercise performed and frequency: _____

Employer: _____

Occupation: _____

GYNECOLOGIC HISTORY:

First Day of Last Menstrual Period: _____ Age of First Period: _____

Current birth control method: _____ Age of Menopause: _____ ☐ N/A

Menstrual Cycle:

☐ Regular ☐ Irregular Days of Flow: _____ Days between Cycle (avg): _____

Describe flow: ☐ Normal ☐ Light ☐ Heavy Cycles per year (avg): _____

Pads or Tampons per Day during Heaviest Cycle days: _____

Pain: ☐ Mild ☐ Moderate ☐ Severe Medications used: _____

Pap Smear History (Cervical Cancer Screening):

Date of Last Pap: _____ Results: _____ Performed by: _____

History of abnormal paps: ☐ None or Describe: _____

If applicable, Menopause: Year _____ Age _____ Surgical or Natural _____

Symptoms: ☐ Hot flashes, night sweats, insomnia ☐ Emotional or memory issues ☐ Vaginal Dryness

Additional space needed?
Check here and finish on last page ☐

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Breast Health: (indicate side or both) Do you perform self breast exams? ☐ Yes No ☐

☐ Breast discharge: _____ ☐ Breast Lump: _____ ☐ Breast Pain: _____

Prior Breast Surgery: (reconstruction, augmentation, reduction, biopsy, lumpectomy, mastectomy _____

_____

Additional History:

Urinary: ☐ Incontinence ☐ Urgency ☐ Frequency

Abnormal: ☐ Bleeding ☐ Discharge ☐ Odor ☐ Itching

History of infertility: (describe treatments) _____

Sexual Health:

Age at First Activity: _____ Number of Sexual Partners: _____ Partners: ☐ Male ☐ Female

History of STI's or STD's: _____ Sexual Orientation: _____

Is sexual activity painful? ☐ Yes No ☐ Relationship Status: _____

History of domestic violence or sexual abuse: ☐ Yes No ☐

CARE GUIDELINES (HEALTH SCREENING) - Bring records if possible

Dates/Results of most recent: Cholesterol Levels _____ Colonoscopy _____

Bone Density Scan _____ Mammogram _____ Diabetes _____

REVIEW OF SYSTEMS ☐ None of the below apply, I have been feeling fine

Check any of the following that apply within the last few weeks					
GENERAL		**CARDIO**		**NERUO/PSYCH**	
Chills	☐	Chest Pain	☐	Headache	☐
Fevers	☐	Edema	☐	Memory loss	☐
Weight gain	☐	Irregular heart beat	☐	Anxiety	☐
Weight loss	☐	Decreased exercise tolerance	☐	Depression	☐
HEENT		**GASTRO**		Insomnia	☐
Hearing loss	☐	Abdominal pain	☐	**MUSCULOSKELETAL**	
Sore throat	☐	Blood in stools	☐	Back pain	☐
Vision changes	☐	Diarrhea	☐	Joint pain	☐
RESPIRATORY		Nausea	☐	Joint swelling	☐
Chronic cough	☐	Vomiting	☐	**HEMATOLOGIC**	
Cough	☐	**REPRODUCTION**		Easy bleeding	☐
Shortness of breath	☐	Hot flashes	☐	Easy bruising	☐
Bloody cough	☐	Irregular periods	☐	**ALLERGIES**	
Wheezing	☐	Vaginal discharge	☐	Seasonal allergies	☐

Additional space needed?
Check here and finish on last page ☐

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ADDITIONAL INFORMATION:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Women's Clinic of Northern Colorado
Care Agreement

After hours care:

- Urgent or Emergent care by a WCNC physician or certified nurse midwife is available 24/7 on call.
- After hours care is triaged through our qualified nurse staffed answering service.

Reflex Testing:

Pap tests may reveal that a patient is at risk for the HPV virus. If your test reveals this, WCNC authorizes the pathologist to automatically order the High Risk Strain HPV test. We recommend HPV testing with a Pap smear for all patients between the ages of 30 and 65. If both tests are normal, you will only need a Pap smear every five years. Tests will be billed to you and your insurance by the pathology provider. If you choose to not allow reflex testing, please inform clinical staff and your provider.

☐ I Accept ☐ I Decline the high-risk HPV testing. _____Staff initials

Gonorrhea & Chlamydia Testing:

WCNC recommends routine gonorrhea and Chlamydia testing for all women 25 and under. This will be done at the same time as your Pap. If you choose to decline this testing, please inform clinical staff and your provider.

☐ I Accept ☐ I Decline Gonorrhea & Chlamydia testing ☐ N/A _____Staff initials

Medication History:

Electronic prescribing enables access to your medication history for any prescriber, which allows your WCNC provider to prescribe medication for you more effectively. Do you agree to access of your medication history by WCNC staff?

☐ I Agree ☐ I Do Not Agree to access of my medication history by prescribers other than WCNC

Colorado Prescription Drug Monitoring Program

If you receive a prescription for a "controlled" (Schedule II through V) drug, your identifying prescription information will be entered into Colorado's electronic Prescription Drug Monitoring Program (PDMP) database when this drug is dispensed to you and may be accessed for limited purposes by specified individuals. You have a right to access your information in the PDMP through the Colorado Board of Pharmacy. You may seek corrections to the information as you would with your other medical records.

Privacy Practices:

I have been offered the opportunity to review, read and understand the WCNC Notice of Privacy Practice.
I hereby consent that my health records may be disclosed to necessary parties for the purposes of my treatment, payment and health care services.
I understand I may revoke my consent at any time; however WCNC is not required to accept my request. Revocation form must be completed and returned to the WCNC to be enforced and in effect the day it is received by WCNC.

Financial Obligations:

I am obliged to understand, agree, and be financially responsible for services rendered to me by WCNC providers.
I agree to pay my balance in full upon receipt of WCNC Statement and letter, phone call, or text message requesting such payment.
I understand and agree that balances over 30 days old will incur a service charge and be considered past due. I authorize the release of any information necessary to process my claims and irrevocably assign all benefits for claims to WCNC.

_____ _____

Patient Signature Date

Sticker

Women's Clinic of Northern Colorado (WCNC)
Consent for the Use or Disclosure of Protected Health Information (PHI)

I understand that as part of my healthcare, WCNC originates and maintains health records describing my history, exam, tests results, diagnoses, treatments: past present and future; as well as costs, payments and adjustments by myself and my health plan.

I, _____, hereby consent to the use, access and disclosure of my PHI for the purposes of:

- planning my care and treatment, including other professionals and facilities that contribute to my care.
- communicating with other professionals who contribute to my care.
- evaluating care quality and professional competence.
- communicating appointments and/or balances on previously rendered and/or charged services for WCNC provider and our agents and assigns.
- supplying diagnostic and procedural information to a third party for the processing of my services and bills related to my service.

I, _____, **hereby consent to the use, access and disclosure of my PHI to:**

☐ Spouse _____ ☐ Parent/Guardian_____

☐ Son/Daughter_____ ☐ Other_____

*By signing below, I understand and give my full consent to be contacted on the landline and/or cell phone number(s) provided to Women's Clinic of Northern Colorado and their assigns, including: appointments, test results, financial information, billing, and marketing material. This express authorization also applies to any landline or cell phone number(s) that I may acquire in the future. Women's Clinic of Northern Colorado and their assigns may also contact me by sending text messages or emails, using any e-mail address I may provide. *NOTE: Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. Providing your phone number(s) is not a condition of receiving services.*

I understand:

- I may request restriction on the uses and disclosures of my **PHI** at any time by completing and signing a restriction request form. I understand that WCNC is not required to accept my restriction request.
- I understand I may revoke this consent at any time by signing a revocation form and returning it to the Medical Records Department at WCNC. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

My signature below acknowledges that I have read and understand and consent to WCNC privacy and disclosure practices.

_____ _____

Signature Date

Risk Assessment for Hereditary Cancer Syndromes

Women's Clinic of Northern Colorado is dedicated to improving your quality of care, committed to your health, and helping with cancer prevention. To best serve you, we need a detailed personal and family cancer history.

Patient Name:_____Date of Birth: _____ Date _____ Insurance Carrier:_____

☐ Y ☐ N Have you ever had genetic testing for a hereditary cancer syndrome (Ex: BRCA, Lynch).

- **If yes, what date?_____ If yes, were you positive or negative?_____**

Please consider the following Family Members when completing this form: (Blood Relatives Only)

- Mother, Father, Sister, Brother, Children: **(1st degree relatives)**
- Aunt, Uncle, Grandmother, Grandfather, Grandchild, Niece, Nephew, Half Siblings: **(2nd degree relatives)**
- Cousins, Great Grandparent, Great Aunt, Great Uncle: **(3rd degree relatives)**

	CANCER	YOU (age)	PARENTS / SIBLINGS / CHILDREN	AGE	MOTHER'S SIDE	AGE	FATHER'S SIDE	AGE
☐ Y ☐ N	*EXAMPLE: BREAST CANCER*		*Sister*	*41*	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐ Y ☐ N	BREAST CANCER							
☐ Y ☐ N	OVARIAN CANCER							
☐ Y ☐ N	COLON/RECTAL CANCER							
☐ Y ☐ N	UTERINE/ENDOMETRIAL CANCER							
☐ Y ☐ N	OTHER CANCER(S) (SPECIFY):							

☐ Y ☐ N Are you of Jewish descent?
What is your Ancestry:_____

Cancer Risk Assessment Review and Counseling

Patient's Signature:_____ Date: _____

Health Care Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED (sign informed refusal)

Informed Refusal Documentation

My provider, has recommended the BRACAnaylsis and/or Colaris and/or myRISK genetic test based on my personal and/or family history of cancer. He/She has explained to me the potential benefits of the genetic test and the risks of not consenting to the genetic test. Despite my provider's recommendation, I decline to consent to the genetic test.

Signature of patient for informed refusal_____

For Office Use Only:

Hereditary Breast and Ovarian Cancer Syndrome

- Breast cancer diagnosed UNDER the age of 50*
- Ovarian cancer at any age*
- 2 primary breast cancers in the same person at any age*
- 2 relatives same side of the family w/ breast cancer, 1 diagnosed at or under age 50**
- 3 or more of the following cancers at any age on the same side of the family: breast, ovarian, pancreatic, prostate**
- Triple negative breast cancer at or under the age of 60*
- Male breast cancer at any age*
- Ashkenazi Jewish ancestry with an HBOC*** associated cancer at any age*

Lynch Syndrome

- 1 Colon, rectal or uterine cancer diagnosed at or under age 50*
- 2 or more w/ a Lynch syndrome cancer****, 1 before the age of 50 and 1 being colon, rectal or uterine cancer**
- 3 or more w/ a Lynch syndrome cancer**** at any age and one being colon, rectal or uterine cancer**

***Self, 1st, 2nd degree family members**
****Self, 1st, 2nd, or 3rd degree family members**
*****HBOC associated cancers: Breast, ovarian, pancreatic**
******Lynch associated cancers: Colon, uterine, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas**