The Women's Clinic of Northern Colorado

Fort Collins
1107 South Lemay Ave
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Phone: (970) 493-7442

Loveland
2500 Rocky Mountain Ave.
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Loveland, CO 80538
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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: (Including Over The Counter and Supplements)

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

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

_____ _____ _____

_____ _____ _____

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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														
BLOOD CLOTS														
AUTOIMMUNE 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:

_____

_____

_____

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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

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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: ☐ Yes No ☐ History of 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/HbA1c _____

HPV Vaccine_____

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 heartbeat		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	