Fort Collins	Loveland
1107 South Lemay Ave	2500 Rocky Mountain Ave.
Suite 300	North Medical Office Building, Suite 150
Fort Collins, CO 80524	Loveland, CO 80538
Phone: (970) 493-7442	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)

____________________________ __________________________ ___________________________

____________________________ __________________________ ___________________________

____________________________ __________________________ ___________________________

____________________________ __________________________ ___________________________

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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

The Women's Clinic of Northern Colorado

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

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

ADDITIONAL INFORMATION:

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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:
By accepting this section you agree to have a Pap test that reveals risk for HPV, further tested for the High Risk Strain of HPV. We recommend HPV testing with a Pap smear for all patients between the ages of 30 and 65. If both tests are normal, a Pap smear every five years is recommended. The pathologist will bill you or your insurance. ☐ 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. A 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 understand that should my account become delinquent and turned over to an attorney and/or collection agency, I will be responsible for all costs of collection, legal fees costs, and attorney fees incurred as a result.
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**