



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:

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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 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	NERVO/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

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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:

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

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

Cancer Family History Questionnaire

Personal Information

Patient Name	Date of Birth	Healthcare Provider	Today's Date
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Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based on your personal and family history of cancer. **The following blood relatives should be considered:** Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family. For cancer sites with a 'first-degree relative' notation, only parents, siblings, and children should be considered.

Do you have a personal history of breast, ovarian, or pancreatic cancer at any age?			<input type="radio"/> Y	<input type="radio"/> N
Do you have a personal history of uterine or colorectal cancer at age 64 or younger?			<input type="radio"/> Y	<input type="radio"/> N
Do you have a family history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side of the family?	Age at diagnosis?
Breast cancer at 49 or younger	<input type="radio"/> Y <input type="radio"/> N		<input type="radio"/> M <input type="radio"/> P	
Two different breast cancers in one relative at any age	<input type="radio"/> Y <input type="radio"/> N		<input type="radio"/> M <input type="radio"/> P	
Three breast cancers in relatives on the same side of the family at any age	<input type="radio"/> Y <input type="radio"/> N		<input type="radio"/> M <input type="radio"/> P	
Ovarian cancer at any age	<input type="radio"/> Y <input type="radio"/> N		<input type="radio"/> M <input type="radio"/> P	
Male breast cancer at any age	<input type="radio"/> Y <input type="radio"/> N		<input type="radio"/> M <input type="radio"/> P	
Ashkenazi Jewish ancestry with breast cancer at any age	<input type="radio"/> Y <input type="radio"/> N		<input type="radio"/> M <input type="radio"/> P	
Pancreatic cancer at any age (1 st degree relative)	<input type="radio"/> Y <input type="radio"/> N		<input type="radio"/> M <input type="radio"/> P	
Metastatic prostate cancer at any age (1 st - degree relative)	<input type="radio"/> Y <input type="radio"/> N		<input type="radio"/> M <input type="radio"/> P	
Colon or uterine cancer at 49 or younger (1 st - degree relative)	<input type="radio"/> Y <input type="radio"/> N		<input type="radio"/> M <input type="radio"/> P	
3 or more breast or aggressive prostate cancers on the same side of the family at any age	<input type="radio"/> Y <input type="radio"/> N		<input type="radio"/> M <input type="radio"/> P	
3 or more colon or endometrial cancers on the same side of the family at any age	<input type="radio"/> Y <input type="radio"/> N		<input type="radio"/> M <input type="radio"/> P	
Do you have a family history of other cancers ?	<input type="radio"/> Y <input type="radio"/> N	List them here:		
Have you or anyone in your family had genetic testing for hereditary cancer?	<input type="radio"/> Y <input type="radio"/> N	Who?	What gene(s)?	What was the result?

Medical History Questions

Height (ft. and in.)	Weight (lbs.)	Age at first menstrual period:
Are you: <input type="radio"/> Pre-menopausal <input type="radio"/> Peri-menopausal <input type="radio"/> Post-menopausal Age at menopause: _____		
Have you ever had a live birth? <input type="radio"/> No <input type="radio"/> Yes Your age at first child's birth: _____		
Have you ever used Hormone Replacement Therapy? <input type="radio"/> No <input type="radio"/> Yes		
If Yes, treatment type? <input type="radio"/> Combined <input type="radio"/> Estrogen Only <input type="radio"/> Progesterone only		
If Yes, are you a: <input type="radio"/> Current user: Started _____ years ago, intended use for _____ more years		
<input type="radio"/> Past user: Stopped _____ years ago		
Please indicate if you have had a breast biopsy showing one or more of the following results:		
<input type="radio"/> N/A (No biopsy or none of the listed results) <input type="radio"/> Hyperplasia <input type="radio"/> Atypical Hyperplasia		
<input type="radio"/> Lobular Carcinoma in Situ (LCIS) <input type="radio"/> Biopsy with unknown or pending results		

Information about your female relatives:	Number of maternal aunts	Number of paternal aunts
Number of daughters: _____	Number of sisters: _____ (mother's sisters): _____	(father's sisters): _____

Cancer Risk Assessment Review (to be completed after discussion with your healthcare provider)

Patient Signature _____	Date _____
Healthcare Provider Signature _____	Date _____
Office Use Only Patient offered hereditary cancer genetic testing? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Accepted <input type="radio"/> Declined	
If yes, which test? <input type="radio"/> BRACAnalysis® with Myriad myRisk® <input type="radio"/> Multisite 3 BRACAnalysis® REFLEX to BRACAnalysis® with Myriad myRisk®	
<input type="radio"/> COLARIS®PLUS with Myriad myRisk® <input type="radio"/> COLARIS AP®PLUS with Myriad myRisk® <input type="radio"/> Single Site Testing <input type="radio"/> Myriad myRisk® Update Test	
<input type="radio"/> Other: _____	
Follow-up appointment scheduled? <input type="radio"/> Yes <input type="radio"/> No	Date of next appointment: _____