

The Women's Clinic of Northern Colorado
Phone (970) 493-7442

1107 S Lemay Ave, Ste 300, Fort Collins • 2500 Rocky Mtn Ave, North MOB, Ste 150, Loveland
New Patient Exam - Intake History Form

Patient Name: _____

DOB: _____ Age: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

This is a NEW PATIENT EXAM. The following comprehensive questions regarding your home environment, work environment and personal history are asked in compliance with national guidelines for wellness exams.

What is your reason for your visit today? _____

Have you been seen at The Women's Clinic in the past? _____

Name of your primary care physician? _____

Pharmacy of choice: _____

Location of pharmacy: _____

Emergency contact: _____ Relation: _____

Phone #: _____

Medical history

List your current allergies, with Reactions:

What medications are you currently taking, including over the counter and herbal supplements? Include strength if known:

Current chronic diseases or conditions:

Previous pregnancies:

Year/date	Hospital	Gestation wks	Delivery type	Baby's weight	Baby's Name	Gender	Complications
-----------	----------	---------------	---------------	---------------	-------------	--------	---------------

Past Surgeries:

Year/date/age Hospital Physician Reason for surgery/hosp Type of surgery Complications

Miscellaneous events: (hospitalizations, colposcopy, LEEP, endometrial biopsies, etc.)

Year/date/age Hospital Physician Reason procedure Type of procedure Complications

Family history

Mother DOB: _____ Father DOB _____

Use the abbreviations below to indicate which members of your family have the following conditions.

M=mother F=father MGM=mother's mother MGF=mother's father PGM=father's mother PGF=father's father
S=sister B=brother MA=mother's sister PA=father's sister MU=mother's brother PU=father's brother C=cousin

Illness	Relative	Illness	Relative
<u>Birth defects</u>	_____	<u>Dementia/Alzheimer's</u>	_____
<u>Fibroids</u>	_____	<u>Depression</u>	_____
<u>Endometriosis</u>	_____	<u>Drinking problem</u>	_____
<u>Diabetes</u>	_____	<u>Breast cancer</u>	_____
<u>Stroke/blood clots</u>	_____	<u>Colon cancer</u>	_____
<u>Heart attack</u>	_____	<u>Ovarian cancer</u>	_____
<u>High Blood pressure</u>	_____	<u>Uterine cancer</u>	_____
<u>Osteoporosis</u>	_____	<u>Cervical cancer</u>	_____
<u>Bleeding problems</u>	_____	<u>Cancer other please specify</u>	_____

Comments: _____

Social history

Lifestyle:

Were you born outside of the US? Yes or No If yes, where? _____

Education level: _____

Employer : _____

Occupation: _____

Present marital/relationship status: _____

Do you live in a nursing home? Yes or No

Any children living in your home? _____

Tobacco Use? Yes or No If yes, number of packs per day: _____

Do you drink caffeine? Yes or No If yes, number of drinks per day: _____

Do you exercise regularly? Yes or No

What type of exercise? _____ How often: _____

Are you on any type of special diet (Atkins, vegetarian, etc)? Yes or No

If yes, please specify? _____

Do you have a Calcium intake of 1200 mgs/day? Yes or No

Have you recently traveled out of the country? Yes or No

Do you receive regular dental care? Yes or No

Safety:

Are there smoke detectors in your home? Yes or No

Are there carbon monoxide detectors in your home? Yes or No

Do you use seat belts every time you drive? Yes or No

Do you feel threatened in your home? Yes or No

Do you regularly use sunscreen? Yes or No

Do you drink alcohol? Yes or No

If yes, how much/how often? _____

Recreational drug use? Yes or No

Gynecologic History:

First day of last menstrual period: _____

Age of first period: _____

Date of last Pap test: _____

Result of last Pap test: _____

Where performed: _____

Do you have a history of abnormal Pap tests? Yes or No

Comments: _____

Menstrual cycle

Do you have regular menstrual cycles? Yes or No

If no, is it because of: hysterectomy pregnancy menopause other: _____ If menopause, when did it occur?

How many days between your periods? _____

How long does your period last? _____

Would you describe your flow as: normal light heavy

How many pads or tampons do you use per day on average? _____

Do you have pain with your pain menstrual cycle? _____ If yes, is it: mild moderate severe

Do you take medications to manage your pain during your cycle? Yes or No

PMS/Menopause Symptoms:

Do your periods cause you to miss school or work? Yes or No

Do you have mood swings and/or become irritable before periods? Yes or No

Do you have bloating or swelling before periods? Yes or No

Do you have hot flashes, night sweats, or insomnia? Yes or No

Do you have emotional outbursts or memory loss? Yes or No

Do you have vaginal dryness? Yes or No

Breasts:

Do you experience breast discharge? Yes or No

Do you have a breast lump? Yes or No

Do you have breast pain? Yes or No

Previous breast surgery: augmentation reconstruction reduction

If so, please indicate details.

Do you do a monthly BSE (breast self exam)? Yes or No

Date of last mammo: _____

Sexuality:

Sexual activity fulfilling: Yes or No
Sexual desire diminished: Yes or No
Problems achieving orgasm: Yes or No
Marital problems: Yes or No
Bleeding with intercourse: Yes or No
Pain with intercourse: Yes or No
Desires sexual information: Yes or No
More than 1 partner in past year: Yes or No
Concern of high risk partner: Yes or No
Number of sexual partners lifetime (circle one): 0 1 2-10 more than 10
Use condoms to prevent STD's: Yes or No
History of STD's: Yes or No
Current birth control method: _____

Urinary Problems:

Any urinary problems at this time: Yes or No
Urinary leaking associated with coughing or sneezing: Yes or No
Urinary leaking associated with strong urge to urinate: Yes or No
Urinary leaking without awareness of when leak occurred: Yes or No
Urinary leaking with pelvic pressure and heaviness: Yes or No

Other:

Do you have history of infertility? Yes or No
Do you have history of ovarian, cervical, breast or uterine cancer? Yes or No
Do you have abnormal vaginal discharge? Yes or No
Do you have vaginal itch? Yes or No

Health Maintenance information:

Date of most recent lipid/cholesterol profile _____
Date of flexible sigmoidoscopy or colonoscopy _____
Date of last osteoporosis screen (DEXA scan) _____

Review of Systems: Are you currently experiencing any of the following: No, I feel fine today
 Yes (please indicate below)

Con: insomnia weight loss or gain fever loss of energy
Heent: eye problems vision loss ear problems hearing loss nose, sinuses, or throat problems
Musc: persistent joint pain body aches muscle pain
Resp: shortness of breath cough coughing blood
Gastro: nausea vomiting intestinal problems constipation diarrhea tarry & black stools
 rectal bleeding
Cardio: chest pain irregular or fast heart beat decreased exercise tolerance
Vasc: swollen ankles swollen or painful veins (varicose veins)
n/p: depression anxiety headaches numbness muscle weakness



Consent for the Use or Disclosure of Protected Health Information

I understand that as part of my healthcare, The Women's Clinic of Northern Colorado originates and maintains health records describing my health history, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I, _____ (print name) hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

I understand that this information serves as:

- A basis for planning my care and treatment, including other healthcare professionals and facilities that contribute care such as pathology and radiology.
- A means for communication among the many healthcare professionals and facilities who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

Please indicate with the following choices that you consent to:

H-Home B-Business C-Cellular A-All O-Other

- _____ Messages/phone calls regarding appointments
_____ Messages/phone calls regarding lab/test results
_____ Messages/phone calls regarding financial account information

Please **initial** below giving consent to the following:

- _____ Receive information by mail regarding appointments
_____ Receive information by mail regarding lab/test results
_____ Receive information by mail regarding marketing or promotion material.

- _____ If married, provide medical or financial information to spouse
_____ If a minor, provide medical or financial information to legal guardians

I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing a restriction request form. I further understand that The Women's Clinic of Northern Colorado is not required to accept my restriction request.

I understand that I may revoke this consent at any time by signing a revocation form and returning it to Medical Records at The Women's Clinic of Northern Colorado. I further understand that any such a 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.

By signing this consent, I acknowledge that I have read and understand The Women's Clinic of Northern Colorado Notice of Privacy Practices statement.

Signature

Date

Patient Sticker

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 30 years and older. If both tests are normal, you will only need a Pap smear every third year. 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 _____ 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

Mammograms:

WCNC supports the American Cancer Society (www.cancer.org) guidelines as follows:

Over 20	Breast Self Exam	Monthly	Report changes/symptoms to your health provider
20-39	Clinical Breast Exam	Every year	
40+	Clinical Breast Exam	Every year	
40+	Mammogram	Every year	Or as may be recommended by your provider

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 or letter 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