Colorado Obstetrics & Women's Health

New Patient Form

Name: _____ Date of Birth: _____

Social History

Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Significant other ☐ Divorced ☐ Widowed

Household: ☐ Live alone ☐ Spouse/ Significant other ☐ Child(ren) ☐ Mother ☐ Father
☐ Roommate(s) ☐ Other _____

Do you feel safe at home? ☐ YES ☐ NO, Explain: _____
☐ Will disclose in office

Employment Status: Employed ☐ Full-time ☐ Part time Occupation: _____
☐ Retired ☐ Disabled ☐ Student ☐ Homemaker ☐ Unemployed

How often do you exercise? ☐ Do not exercise
☐ Occasionally do: ☐ Walking/ Yoga/ Other light activity
☐ Cardio/ Aerobic/ Interval Training
☐ Weight lifting/ Other resistance exercise

☐ Regularly do: ☐ Walking/ Yoga/ Other light activity
☐ Cardio/ Aerobic/ Interval Training
☐ Weight lifting/ Other resistance exercise

Any alcohol use? ☐ YES ☐ NO
If yes, how often? ☐ Regularly ☐ Occasionally ☐ Socially ☐ Rarely
☐ Former drinker ☐ Recovering alcoholic

Any tobacco use? ☐ YES ☐ NEVER ☐ Former smoker, quit _____ (age/ year)
If yes, what type? ☐ Cigarettes ☐ Cigars ☐Snuff ☐ Chewing tobacco ☐ Pipe ☐ Vaporized
How long have you used tobacco products? _____
How many packs per day? _____ ☐ Vapor used as desired

Any marijuana use? ☐ Medical Use ☐ Recreational Use ☐ CBD only ☐ Former smoker ☐ None
If yes, what type? ☐ Smoking ☐ Vaporized ☐ Edibles ☐ Spray ☐ Tincture ☐ Topical
How often? ☐ Regularly ☐ Occasionally ☐ Socially ☐ Rarely

Any illicit drug use? (i.e. heroin, cocaine, methamphetamines, etc…) ☐Never used
☐ Current user, type(s): _____ Last use: _____
☐ Former user, type(s): _____ Last used: _____
☐ Will not disclose ☐ Will disclose in office

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Well Woman Information: (Please provide dates where applicable)

Last Pap smear _____ (month/year) Result? _____
History of abnormal Pap smears? ☐ YES ☐ NO If yes, when? _____ (year)
Colposcopy completed? ☐ YES ☐ NO If yes, when? _____ (year)
Cervical Dysplasia (precancerous cells of cervix) ☐ YES ☐ NO
If yes, any treatment(s)? (Please Provide Dates)
☐ Cryotherapy (freezing) _____ (year) ☐ Cone Biopsy _____ (year)
☐ LEEP Procedure _____ (year) ☐ Hysterectomy _____ (year)

Current method of birth control: _____ ☐ Same sex partner
Birth control history:

☐ None	☐ Condoms	☐ Pill	☐ Patch
☐ Depo Provera	☐ Nexplanon	☐ Nuvaring	☐ IUD
☐ Tubal Ligation	☐ Vasectomy	☐ Essure	☐ Other _____

Last mammogram _____ (month/year) Result? _____
Last DEXA (bone density scan) _____ (year) Result? _____
Last colonoscopy _____ (month/year) Result? _____

Menstrual History:

Age at menarche (first period): _____ years old.
First day of last menstrual period? _____
Was the flow: ☐ Light/Moderate ☐ Moderate ☐ Moderate to Heavy ☐ Heavy ☐ Very Heavy
Menstrual cramps? ☐ None ☐ Mild ☐ Moderate ☐ Severe
History of abnormal menstrual cycles? ☐ YES ☐ NO
Are your cycles: ☐ REGULAR How far apart are you menstrual cycles? _____ days
☐ IRREGULAR Menstrual cycles start every _____ to _____ days
Length of menses? _____ days Any spotting/bleeding between periods? ☐ YES ☐ NO

Medications & Allergies: (Please provide dosage) **or check:** ☐ NONE

Prescribed Medications (with instructions)	Vitamins/ Herbal Supplements
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Over the Counter	Allergies (provide reactions)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Past Medical History: Do you currently have or have history of (H/O): **or check:** ☐ NONE

☐ Gynecologic/ Sexual Problems

☐ PCOS	☐ Endometriosis	☐ Chronic/Frequent yeast infections
☐ Ovarian cysts	☐ Lichen sclerosis	☐ Chronic/Frequent bacterial vaginosis
☐ Fibroids	☐ Atrophy	☐ Pelvic inflammatory disease
☐ *H/O Abnormal Paps	☐ *H/O STD/HPV	☐ *Other

*Specify: _____

☐ Hormones/ Thyroid Problems

☐ Hypothyroidism	☐ Hyperthyroidism	☐ Hashimoto's
☐ Grave's disease	☐ Thyroid Nodules	☐ *Other

*Specify: _____

☐ Breast Problems

☐ Breast lumps/ masses	☐ Fibrocystic breasts	☐ Mastalgia (breast pain)
☐ Breast cysts	☐ Mastitis	☐*Other

*Specify: _____

☐ Cancer

☐ Breast Cancer	☐ Uterine Cancer	☐ Ovarian Cancer
☐ Cervical Cancer	☐ Vaginal Cancer	☐ *Other

*Specify: _____

☐ Blood/ Heart/ Vessels

☐ High blood pressure	☐ High cholesterol	☐ Diabetes type ____
☐ Mitral valve prolapse	☐ Blood clots/ DVT	☐ Have a Pacemaker/ Defibrillator
☐ *Bleeding disorder	☐ Heart attack	☐ *Other

*Specify: _____

☐ Respiratory

☐ Asthma	☐ Sleep apnea	☐ Allergic rhinitis
☐ COPD	☐ Emphysema	☐ *Other

*Specify: _____

☐ Skin/ Skeletal/ Muscle:

☐ Osteopenia	☐ Osteoporosis	☐ Fibromyalgia
☐ Scoliosis	☐ Arthritis	☐ Muscular dystrophy
☐ H/O MRSA/ or VRE	☐ Eczema	☐ *Other

*Specify: _____

☐ Mental Disorders

☐ Depression	☐ Anxiety	☐ Bipolar
☐ PTSD	☐ ADD	☐ ADHD
☐ Autism	☐ *Eating disorder	☐ *Other

*Specify: _____

☐ Brain/ Nervous System, specify: _____

☐ Head/ Neck Issues, specify: _____

☐ Urinary/ Kidneys, specify: _____

☐ Abdominal/ Intestinal, specify: _____

***Any other diagnoses or problems/ issues not listed above? ***

_____ _____

_____ _____

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Past Obstetrical/ Gynecological Surgeries: Check any that apply or check: ☐ NONE

Surgery	Year	Surgery	Year
☐ D&C	_____	☐ Tubes removed ☐ L ☐ R ☐ Both	_____
☐ Cesarean section	_____	☐ Ovarian cyst(s) removed ☐ L ☐ R ☐ Both	_____
☐ Infertility Surgery	_____	☐ Ovary removed ☐ L ☐ R ☐ Both	_____
☐ Tuboplasty	_____	☐ Ovarian Surgery ☐ L ☐ R ☐ Both	_____
☐ Tubal Ligation	_____	☐ Vaginal or bladder repair for prolapse or incontinence	_____
☐ Hysteroscopy	_____	☐ Hysterectomy (vaginal)	_____
☐ Laparoscopy	_____	☐ Hysterectomy (abdominal)	_____
☐ Myomectomy	_____	☐ Other _____	_____

Other Surgical History: (Please include estimated date or year)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Anesthesia complications? ☐ NO ☐ YES, Explain: _____

Obstetrical History: ☐ Never been pregnant

Please list all pregnancies, including miscarriages, abortions, ectopic pregnancies, etc…

Result: Full term (37+ weeks), Preterm (before 37 weeks), Miscarriage (include how far along), etc…
Anesthesia: epidural, spinal, local, general **Type:** vaginal, c-section, forceps or vacuum
Complications: Examples: preeclampsia, gestational diabetes, post partum hemorrhage, hypertension, D&C for retained placenta, reason for c-section or early induction, tears/ episiotomies, etc…

Result	Sex	Year	Type	Weeks	Labor Length	Anesthesia	Complications
Ex: Full term	F	2003	Vaginal	39	12 hours	Epidural	Gestational diabetes
Ex: Miscarriage	---	2005	---	8	---	---	D&C

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Family History: ☐ Adopted ☐ Paternal history unknown ☐ Maternal history unknown

Mother: ☐ Living ☐ No longer living, age at death: ____, Cause: _____
Father: ☐ Living ☐ No longer living, age at death: ____, Cause: _____
Sibling(s): ☐ # Living ___ ☐ # No longer living ___, age(s) at death: _____,
Cause(s): _____

☐ **Unremarkable Family History**

History is regarding children, parents, siblings, grandparents, aunts and uncles.
Please exclude "great" family members, cousins, nieces/ nephews, etc…
PLEASE SPECIFY MATERNAL OR PATERNAL SIDE
(Write "Extensive on ____ side" if more than 3 family members have diagnosis)

	Affected Relatives	**Age/Pre or Post Menopausal?**	**Treatment/ Deceased from cancer?**
Example:	Maternal Grandmother	Post menopausal	Lumpectomy
☐ Breast Cancer			
☐ Uterine Cancer			
☐ Ovarian Cancer			
☐ Cervical Cancer			
☐ Vaginal Cancer			

Family history of:	**Affected Relatives *specify additional details if applicable***
☐ Anemia/ Blood disorders	
☐ HIV/ AIDS	
☐ Birth defects/ Inherited diseases	
☐ Cancer	
☐ Diabetes	
☐ Female/ Sexual problems	
☐ Heart Disease/ Heart Attacks	
☐ High blood pressure	
☐ High cholesterol	
☐ Hepatitis/ Liver disease	
☐ Renal Disease (kidneys)	
☐ Stomach or Bowel problems	
☐ Tuberculosis/ Pulmonary disease	
☐ Skin/ Skeletal/ Muscle	
☐ Other medical problems	

Patient Signature: _____ **Date:** _____

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