Boulder Women's Clinic, P.C.

Christine Hansen, MD
Jennifer Stanzel, PA-C Kathryn Johnson, PA-C

Today's date_____

Personal History

Name_____ DOB_____

Occupation _____ University (students) / Employer _____

Ethnic background _____ Who referred you to our office? _____

Who is your primary care / internist / family provider? _____

If you have medication allergies, list the medicines to which you are allergic and your reaction:_____

_____

List all medications you are currently taking and why: _____

_____

_____

List all supplements and / or herbal medications you are currently taking: _____

_____

_____

Please list all surgeries and date done: _____

_____

When was your last tetanus shot? _____ Did you get any / all of the Gardasil / HPV / cervical cancer shots? _____

Are you currently sexually active? ❑yes ❑no ❑not yet Is / are your partners ❑male ❑female ❑both

Marital status ❑Single ❑Married ❑Significant other ❑Separated ❑Divorced ❑Widowed ❑ Other_____

How long have you had the same sexual partner? _____

If applicable, what are you using for birth control? _____

How long have you used the same birth control? _____ Are you happy with your current birth control? ❑yes ❑no

What else have you used for birth control?_____

How old were you when your periods began? _____

Are you still having periods? _____ When was your last period?_____ Was it normal? _____

How long from the first day of a normal period to the first day of the next period?_____

How many days do you usually bleed with your period? _____ Do you have any bleeding during / after sex?_____

Do you have bleeding between your periods? ❑yes ❑no If yes, explain: _____

With your periods, do you have? ❑pain ❑cramps ❑bloating ❑missed work or school because of periods

If you are post-menopausal and have had any vaginal bleeding, please describe it. _____

Have you ever had hormone replacement therapy? ❑yes ❑no If yes, explain: _____

_____

Do you have any of the following: ❑increased abdominal size ❑urinary urgency ❑bloating ❑decreased appetite

❑change in bowel/bladder habits ❑abdominal or pelvic pain ❑pain with sexual intercourse ❑abdominal or pelvic masses

❑hot flashes / night sweats ❑vaginal dryness ❑problems with sleep ❑changes in mood or difficulty concentrating

❑vaginal discharge ❑pain or bleeding with intercourse Do you wish to be checked for STDs today? ❑No ❑Yes

Have you ever been diagnosed and/or treated for the following:

❑vaginal infection ❑oral herpes ❑genital herpes ❑genital warts ❑Chlamydia ❑Other infections _____

Do you currently have sexual difficulty or physical or emotional discomfort in your relationship? _____

Please list how many: Pregnancies _____ Premature babies_____ Miscarriages _____ Abortions _____

Living Children_____ Children you adopted_____ Children you gave up for adoption_____

Pregnancy history

Date	Gender	Type of Delivery	Complications	Name

Have you ever been concerned about or tested for infertility? _____

Past Medical and Family History

Father Age, if living_____ Health / medical concerns _____

Age at death, if deceased_____ Cause of death_____

Mother Age, if living_____ Health / medical concerns _____

Age at death, if deceased_____ Cause of death_____

Brother(s) Age, if living_____ Health / medical concerns _____

Age at death, if deceased_____ Cause of death_____

Sister(s) Age, if living_____ Health / medical concerns _____

Age at death, if deceased_____ Cause of death_____

Please indicate if you or anyone in your family ever been diagnosed with the following:

	Self	Family	Who / age / details			Self	Family	Who / age / details
Breast cancer					Endometriosis			
Ovarian cancer					Osteoporosis			
Colon cancer					Multiple miscarriages			
Uterine cancer					Uterine fibroids			
Other cancer					Ovarian cysts			
Skin disease					Anxiety			
Thyroid disease					Depression			
Heart disease					Mental health issues			
High blood pressure					Diabetes			
High cholesterol					Anemia			
Liver disease					Bleeding problems			
Kidney disease					Blood clots			
Neurologic disease, i.e., MS, Alzheimers					Other			

Did your mother take DES when she was pregnant? _____

When was your last Pap smear? _____ Have you ever had an abnormal Pap smear? _____ If so, when?_____

If you have had an abnormal Pap smear, describe diagnosis and further testing or treatment: _____

When was your last mammogram?_____ Have you ever had an abnormal mammogram? _____

Have you ever had bone density testing? ❑No ❑Yes When? _____ Result? _____

Do you eat dairy or have other sources of calcium in your diet? _____

Have you ever had a colonoscopy? ❑No ❑Yes When?_____ When are you supposed to get your next colonoscopy? _____

Do you: ❑ Smoke cigarettes If so, how much? _____ /day For how long? _____

❑ Drink alcohol – how many drinks a week? _____ ❑ Drink Caffeine – how many servings a day? _____

❑ Use marijuana – how many times a week?_____ ❑ Use other recreational drugs? _____

What do you do for exercise? _____

How often do you exercise? _____/week

Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?
❑ Not at all ❑ Several days ❑ More than ½ the days ❑Nearly every day

Over the past 2 weeks, how often have you felt down, depressed or hopeless?
❑ Not at all ❑ Several days ❑ More than ½ the days ❑Nearly every day

Many women have dealt with or are dealing with an abusive relationship or sexual assault. Has this ever been a concern for you?
❑No ❑Yes Is this something you would like discuss? ❑No ❑Yes

What is the **primary** reason for your appointment today?

Any comments / questions today?