Canyon View

Women's Health

Community HOSPITAL

2373 G Road, Suite 240
Grand Junction, CO 81505
Phone (970) 243-7908
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Provider you are scheduled to see:

□ Elizabeth McCarrel, M.D. □ Kara Danner, M.D.
□ Tiffini Young, CNM □ Analiesa Leonhardt, CNM □ Sarah Rauch, CNM □ Sue Hanson, CNM

Patient Information Update

Date: ____________________

Full Name: ________________________ **Preferred Name:** __________________ **Maiden Name:** ___________________

Date of Birth: ______________ **Social Security Number**: _______________ **Preferred Pharmacy:** ___________________

Marital Status: Single Married Divorced Widow Primary Language: ____________________

Significant other's name: __________________________ Date of Birth: ______________________

Race: □American Indian/Alaska Native □Asian □Black/African American
□Nat Hawaiian/Pacific Islander □White □ Other □ Decline

Ethnicity: □Hispanic or Latino □ Not Hispanic or Latino □Unknown □ Declined Religion: ________________________

Mailing Address: ____________________________ **City:** _______________________ **State:** ________ **Zip:** __________

Primary Number: _________________________ **Work:** _______________________ **Cell:** __________________________

Employer: ______________________________ **Occupation:** ________________________ **Education:** ________________

Email Address: __________________________ **Emergency Contact:** _____________________ **Phone:** _______________

□ **Self-Pay** □ **Insurance Company/Prescriber & D.O.B, if other than self:**_________________________________
May we leave messages regarding appointments or request for your call back on an answering machine? (Information includes doctor's name and appointment day/time) □Yes □No If yes, telephone number: ______________________

Patient Medical History

What brings you to our office today? **Height:** __________________

□ Routine GYN check-up □ Pregnancy □ Other (please explain): ____

Who is your primary care physician? _______________________ **Referring physician?** ____________________________

Are you allergic to any medications? □Yes □No

Type	Reaction

Social History

Are you sexually active? □Yes □No Any new partners within the last year? □Yes How many? _____ □ No
Is your relationship monogamous? □Yes □No

Sexual preference: □Heterosexual □Homosexual □Bisexual □Decline

Have you ever been sexually abused or assaulted? □Yes □No If yes, what age? ____________

Do you ever feel unsafe at home? □Yes □No Have you ever felt afraid of your partner? □Yes □No

Please check all that apply:

□ Tobacco How many per day? ___________ For how many years? _______ Quit? When: _______________

□ Chew How much per day? ___________ For how many years? _______ Quit? When: _______________

□ Alcohol How much? _________________ □ Caffeine/Coffee How much? ________________

□ Recreational Drugs What type? ________________ How often? ___________ Quit? When: _____________

Any sexual partners with IV drug use? □Yes □No

Have you ever been treated for a drug or alcohol disorder? □Yes □No If yes, when? _________________

Gynecological History

Age of first cycle: ________ Date of your last menstrual cycle: ____________ Was it normal? □Yes □No

Number of days between cycles: ________ Menstrual flow is: □Light □Medium □Heavy

Do you have any of the following with your menses? (Please check all that apply)

□ Pain with or prior to your menstrual cycle □ Clots with cycle

□ Bleeding between cycles □ Abnormal vaginal bleeding

□ Bleeding during or after intercourse □ Pain with intercourse

Method of birth control:

□Condoms □Pills □Patch □Vaginal ring □Tubal □Essure □IUD: Which one? ____________

□Hysterectomy □Partner with vasectomy □None □Other _____________________

Have you had any of the following?

□Fibrocystic breasts □Endometriosis □Ovarian cysts □Uterine fibroids

Date of last Pap Smear: ___________________ Result: □Normal □Abnormal

If abnormal, did you have any of the following procedures?

□Colposcopy □Cryosurgery □LEEP □None

Date of last Mammogram: _________________ Result: □Normal □Abnormal

Do you know how to do a self-breast exam? □Yes □No

Do you examine your breasts monthly? □Yes □No

Date of last Bone Density: _________________ Result: □Normal □Abnormal

Date of last Colonoscopy: _________________ Result: □Normal □Abnormal

Have you experienced Menopause? □Yes □No (If yes, please check all that apply)

□Abnormal bleeding □Hot flashes □Lumps in your breasts □Discharge from your nipples

□Loss of urine when you cough or sneeze □Vaginal dryness □Pain with intercourse

If menopausal, have you ever used hormone replacement therapy? □Yes □No

Pregnancy History

Total number of pregnancies: __________ Number of stillbirths: _________________

Number of living children: _____________ Number of miscarriages: ______________

Number of premature births: ___________ Number of abortions: _________________

Please list pregnancies - starting with most recent

Date:	Sex:	Weight:	Complications: preterm labor, diabetes, high blood pressure, c-section

Have you been treated for infertility? □Yes □No

If yes, please describe when and the treatment received: ____

____

Medications

(Prescriptions, over-the-counter, vitamins, herbal/alternative meds)

Medication Name:	Dosage:	How Often:

Operations

(Starting with the most recent)

Year:	Type	Complications:

Immunizations & Sexually Transmitted Diseases

Date of last Tetanus: ________________

Date of last Measles, Mumps, and Rubella (MMR): ________________

Date of Human Papillomavirus Vaccine (HPV): ______________

Have you ever had any of the following?

□ German Measles When: _____________

□ Chicken Pox When: _____________

□ Vaginal Herpes (HSV) When: _____________

□ Chlamydia When: _____________

□ Gonorrhea When: _____________

□ Pelvic Infection When: _____________

□ Human Papillomavirus (HPV) When: _____________

□ Yeast Infection When: _____________

□ Bacterial Infection When: _____________

Treated? □ Yes □ No

Treated? □ Yes □ No

Treated? □ Yes □ No

Please Check All That Apply

Cardiovascular

□ History of High Blood Pressure
□ Irregular Heart Beat
□ Blood Transfusion
Date: ____________
□ Anemia
□ Chest Pain
□ Varicose Veins
□ History of Mitral Valve Prolapse
□ Heart Disease or Murmurs
□ History of Blood Clots in Legs

Urinary

□ History of Kidney Infection
□ History of Kidney Disease
□ Blood or Sugar in Urine
□ History of Bladder Infection
□ History of Kidney Stones

Metabolic

□ Thyroid Problems
□ Diabetic
□ Weight varied over 10 LBS in last year

Respiratory

□ Asthma
□ Chronic Cough
□ Shortness of Breath

Nose, Mouth, & Throat

□ Frequent Nose Bleeds
□ Dentures
□ Sore, Sensitive, Bleeding Gums

Neuromuscular

□ History of Convulsions
□ Paralysis or Deformity
□ Hearing Impaired
□ Glasses
□ Swollen, red, or Stiff Joints

Gastrointestinal

□ Special Diet
□ Bloody/Tarry Stools
□ Chronic Constipation/Diarrhea
□ Gallbladder Disease, Jaundice, Colitis, Hepatitis

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not At All**	**Several Days**	**More than Half the Days**	**Nearly Every Day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

□ **None of the above**

Family History

(Please indicate if **you** or **any** member of your family has ever had any of the following)

The following family members should be considered: Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins Niece/Nephew Maternal Grandmother/Grandfather

			SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
□ Yes	□ No	Diabetes	______	__________________	____________________
□ Yes	□ No	Heart Disease	______	__________________	____________________
□ Yes	□ No	Hypertension	______	__________________	____________________
□ Yes	□ No	Uterine (endometrial) cancer before age 50	______	__________________	____________________
□ Yes	□ No	Colorectal Cancer before age 50	______	__________________	____________________
□ Yes	□ No	Two or more Lynch syndrome cancers* in the same person or on the same side of the family	______	__________________	____________________

(*Lynch syndrome cancers include: colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain or sebaceous adenomas)

□Yes	□No	Breast cancer at age 50 or younger	______	__________________	____________________
□Yes	□No	Ovarian cancer	______	__________________	____________________
□Yes	□No	Two unrelated breast cancers in the same person or on the same side of the family	______	__________________	____________________
□Yes	□No	Male breast cancer	______	__________________	____________________
□Yes	□No	Triple negative breast cancer (ER-, PR-, HER2- pathology)	______	__________________	____________________
□Yes	□No	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family	______	__________________	____________________
□Yes	□No	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person	______	__________________	____________________

□Yes □No Have you or any member of your family ever been tested for hereditary risk or cancer?

If yes, please explain: ____

____

Patient Signature: ____ **Date:** __________________________