Boulder Medical Center

Boulder Medical Center Obstetrics and Gynecology

HEALTH HISTORY FORM: NEW PATIENTS

Visit date: DD MM YEAR

Patient name: Date of birth: DD MM YEAR

Primary care physician: Referred by:

Preferred pharmacy:

Concerns to discuss with provider: Preferred pronouns: She/her, they/them, he/him

MEDICAL/SURGICAL HISTORY

Do you have or have had any of the following medical problems?

- ☐ Anemia
- ☐ Anorexia
- ☐ Anxiety
- ☐ Autoimmune condition:
- ☐ Asthma
- ☐ Bulimia
- ☐ Blood transfusion
- ☐ Cancer:
- ☐ Crohns disease
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Depression
- ☐ Diabetes
- ☐ DVT (Deep venous thrombosis/blood clot)
- ☐ Endometriosis
- ☐ Fibrocystic/dense breasts
- ☐ Fibroids
- ☐ GERD (Gastroesophageal reflux)
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Hemophilia
- ☐ High blood pressure (Hypertension)
- ☐ High cholesterol
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Migraines ☐ with aura
- ☐ Osteopenia/ Osteoporosis
- ☐ Ovarian cysts
- ☐ Pacemaker
- ☐ Polycystic ovarian syndrome (PCOS),
- ☐ Psychiatric illness
- ☐ Pulmonary embolism
- ☐ Seizure disorder (Epilepsy)
- ☐ Stroke/CVA (Cerebrovascular accident)
- ☐ Thyroid disorder
- ☐ Ulcerative colitis
- ☐ Other:

Allergies to medications:

Current Medications (please include supplements):

Medication	Dose	Medication	Dose

Have you ever had the following surgeries?

Surgery	Year	Surgery	Year
☐ Appendectomy (Removal of appendix)		☐ Hemorrhoid surgery	
☐ Breast augmentation		☐ Hernia repair	
☐ Breast reduction		☐ Hip replacement (left / right)	
☐ Breast surgery or biopsy		☐ Hysterectomy with ovaries retained	
☐ C-Section		☐ Hysterectomy with removal of ovaries	
☐ Cholecystectomy (Removal of gallbladder)		☐ Knee replacement (left / right)	
☐ Cold knife cone or LEEP of cervix		☐ Laparoscopy	
☐ D&C		☐ Neck/Spine surgery	
☐ Endometrial ablation		☐ Orthopedic surgery	
☐ Heart surgery		☐ Ovary removal/ovarian cyst removal	
☐ Tubal ligation (salpingectomy, Essure, other)			
☐ OTHER:			

PREVENTIVE CARE

Screening Test	Last year completed	Result	Guidelines for low risk patients
Pap test	☐ N/A		Every 3 years after age 21
Mammogram	☐ N/A		Every 1-2 years after age 40
Colon cancer screen	☐ N/A		Every 1-10 years after age 45-50
Cholesterol blood test	☐ N/A		Every 3-5 years after age 40
Thyroid blood test	☐ N/A		If symptomatic or personal/family history
Diabetes blood test	☐ N/A		Every 3 years after age 40
HIV blood test	☐ N/A		At least one lifetime test
Hepatitis C blood test	☐ N/A		At least one lifetime test
Bone density test	☐ N/A		Every 2-5 years after age 65
Dental exam			Yearly
Skin check			Yearly

History of abnormal pap(s)? ☐ No ☐ Yes:
Year/ Outcome/ Treatment:

Do you use sun protection? ☐ No ☐ Yes
Do you wear a bike helmet? ☐ No ☐ Yes
Do you wear a seatbelt? ☐ No ☐ Yes

Do you have firearms in the home? ☐ No ☐ Yes
Do you get calcium in your diet? ☐ No ☐ Yes
Have you ever considered suicide? ☐ No ☐ Yes

FAMILY HISTORY

Do any blood-related family members have a history of the following medical problems?

☐ Unknown/adopted

	Relationship		Relationship
☐ Breast cancer		☐ Heart disease	
☐ Colon cancer		☐ Osteoporosis	
☐ Diabetes		☐ Ovarian cancer	
☐ Skin cancer		☐ Uterine cancer	
☐ DVT/blood clots		☐ Other cancer	
☐ High blood pressure		☐ Depression/psychiatric disorder	
☐ Thyroid disease		☐ Other:	

SOCIAL HISTORY

Marital status:

☐ Single ☐ Engaged ☐ Partnered ☐ Married ☐ Widowed ☐ Divorced

Substance use:

Substance	Yes	No		
Alcohol (current)	☐	☐	Drinks per day:	☐ Beer ☐ Wine ☐ Liquor
Marijuana (current)	☐	☐	Days used per week:	Years of use:
Injection drug use (ever)	☐	☐	Type:	Year of last use:
Current Tobacco Use	☐	☐	Pack per day:	Years of use:
History of Tobacco Use	☐	☐	Year of last use:	Years of use:
Misuse of prescription drugs?	☐	☐	Medication:	

Describe your diet:

☐ Healthy ☐ Average ☐ Poor ☐ Vegetarian ☐ Other: _____

Describe your exercise:

☐ Sedentary ☐ Active but no formal exercise ☐ Regular exercise

Do you have any concerns about your weight? _____

Employment: _____

IMMUNIZATIONS

Have you Received:	Yes	No	If Yes, Date Given (if known):
HPV Vaccine series?	☐	☐	
Flu Shot this flu season?	☐	☐	
TDAP Vaccine? (whooping cough)	☐	☐	
Hepatitis B Vaccine series?	☐	☐	
Shingles Vaccine? (50+)	☐	☐	
Pneumonia Vaccine? (65+)	☐	☐	

GYNECOLOGIC HISTORY

Age at first period: ☐

Date of last menstrual period: DD MM YEAR

Heavy periods: ☐ No ☐ Yes

Number of days between periods: ☐

Painful periods: ☐ No ☐ Yes

Bleeding in between periods: ☐ No ☐ Yes

Any period concerns?

Are you currently trying to conceive or planning pregnancy within the next year? ☐ No ☐ Yes

Have you been sexually active within the past year? ☐ No ☐ Yes

If yes: How many partners in last year? ☐ ☐ Men only ☐ Women only ☐ Both

Current method of contraception (if applicable):

Have you ever had any of the following sexually transmitted infections (STIs)?

- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Genital herpes
- ☐ Genital warts
- ☐ Other:
- ☐ Pelvic inflammatory disease
- ☐ HIV
- ☐ Hepatitis B or C
- ☐ Trichomoniasis
- ☐ Syphilis

Would you like to be screened for any STIs today? ☐ No ☐ Yes:

Do you have frequent vaginal or urinary tract infections? ☐ No ☐ Yes:

PERSONAL SAFETY

Have you ever been physically injured by a partner? ☐ No ☐ Yes

Have you ever felt afraid, controlled, or isolated by a partner? ☐ No ☐ Yes

Do you have any concerns for your personal safety? ☐ No ☐ Yes

PREGNANCY HISTORY

History of infertility: ☐ No ☐ Yes:

Have you ever been pregnant? ☐ No (skip remainder of section) ☐ Yes:

How many of the following?

Full term: Preterm: Miscarriage: Abortion: Ectopic:

Please complete for all pregnancies in order:

Type: miscarriage, ectopic, abortion vaginal, cesarean	Gestational age (weeks)	Year	Weight (if applies)	Comments/complications	Living (yes/no) (if applies)

History of preeclampsia or high blood pressure of pregnancy?

History of gestational diabetes?

REVIEW OF SYSTEMS

Please check if you have had any of the following in the last month:

Constitutional:	☐ Weight gain/loss	☐ Night sweats/hot flashes	☐ Unusual fatigue	☐ Fever/chills
HEENT:	☐ Vision/hearing change			
Respiratory:	☐ Cough	☐ Shortness of breath		
Cardiovascular:	☐ Chest pain	☐ Palpitations	☐ Leg swelling	
Gastrointestinal:	☐ Nausea/vomiting	☐ Change in bowels	☐ Abdominal pain	
Genitourinary:	☐ Pain with urination	☐ Blood in urine	☐ Urinary frequency	
	☐ Leakage of Urine	☐ Prolapse	☐ Urinary urgency	☐ Other:_____
Reproductive:	☐ Lack of menses	☐ Painful menses	☐ Heavy menses	
	☐ Irregular Periods	☐ Breast lumps	☐ Breast pain	☐ Nipple discharge
	☐ Pain with sex	☐ Vaginal itch	☐ Abnormal discharge	☐ Change in vaginal odor
Skin:	☐ Hair concerns	☐ Rash	☐ Change in mole	
Neurologic:	☐ Dizziness/Fainting	☐ Headache	☐ Unsteady Gait	
Psychiatric:	☐ Depression	☐ Anxiety	☐ Sleep disturbance	
Metabolic:	☐ Cold/heat Intolerance	☐ Abnormal thirst		
Musculoskeletal:	☐ Back pain	☐ Muscle weakness	☐ Joint pain	☐ Neck pain
Hematologic:	☐ Easy Bleeding	☐ Easy Bruising	☐ Enlarged lymph nodes	
Immunologic:	☐ Contact allergies	☐ Food allergies	☐ Seasonal allergies	

OB.55 09/20