



Boulder Women's Clinic, P.C.

Christine Hansen, MD Mary Macsalka, MD Robert Macsalka, MD
Jennifer Lau Stanzel, PA Nancy Peterson, PA Liliias Skilbred, PA

Date _____

PERSONAL HISTORY

Name _____ DOB _____ Age _____

Occupation _____ Employer _____

Ethnic background _____ Referred by _____

Primary Care Physician _____

Relationship Status (circle) S M W D Sep. Sig. Other

PAST MEDICAL AND FAMILY HISTORY

If living (L), please indicate state of health. If deceased (D) please indicate cause of death.

Father (age) _____ (L)____ (D)____

Mother (age) _____ (L)____ (D)____

Brothers (ages) _____ (L)____ (D)____

Sisters (ages) _____ (L)____ (D)____

Have you or any members of your immediate family had the following:

	No	Yes	Who		No	Yes	Who
Breast Cancer	_____	_____	_____	High Blood Pressure	_____	_____	_____
Colon Cancer	_____	_____	_____	Kidney Disease	_____	_____	_____
Ovarian Cancer	_____	_____	_____	Endometriosis	_____	_____	_____
Uterine Cancer	_____	_____	_____	Osteoporosis	_____	_____	_____
Other Cancer	_____	_____	_____	Blood clots	_____	_____	_____
Diabetes	_____	_____	_____	Multiple miscarriages	_____	_____	_____
Heart Disease	_____	_____	_____				

Have you ever been hospitalized? (Please list year and reason below).

Have you ever had surgery? (Please list year and reason below).

Name: _____ DOB: _____

REVIEW OF BODY SYSTEMS

Please check those problems which apply to you:

HEAD & NECK

Headaches _____
 Migraines _____
 Thyroid disease _____

BREAST

Self-Breast exam monthly _____
 Breast Surgery _____
 Family history of breast cancer _____

HEART

Heart disease _____
 High blood pressure _____
 Irregular heart beats _____
 Shortness of breath _____
 Heart murmur _____

LUNGS

Chronic cough _____
 Respiratory disease _____

GASTRO-INTESTINAL TRACT

Food Allergies _____
 Prolonged nausea/vomiting _____
 Diarrhea _____
 Change in bowel habits _____
 Blood in bowel movements _____
 Hemorrhoids _____
 Abdominal pain _____

LIVER/GALLBLADDER

Gallbladder problems _____
 Jaundice (yellowing of skin) _____
 Hepatitis _____

BLOOD

Do you bruise easily? _____
 Anemia _____
 Blood transfusion? _____ When _____
 Immune disorder _____

GENITOURINARY TRACT

Burning/frequency of urination _____
 Bladder/kidney infections _____
 Urine loss with cough/sneeze _____
 Urinary urgency _____

NEUROMUSCULAR

Arm or leg pain _____
 Numbness/tingling _____
 Fainting _____

SKIN

Acne _____
 Moles removed _____
 Skin cancer _____

PSYCHIATRIC

Hospitalized _____
 When? _____
 Where? _____
 Medications? _____

List all medications you are currently taking: _____

Do you take any supplements and/or herbal medications? _____

Are you allergic to any medications? _____

Name: _____ DOB: _____

SOCIAL HISTORY

HT _____ Weight _____ Do you consider yourself overweight? _____
 Do you smoke? _____ How much? _____ For how long? _____
 Do you exercise regularly? _____ What do you do for exercise? _____
 How many alcoholic drinks per week? _____ How many caffeinated drinks per day? _____
 Do you use any recreational drugs? _____
 Average intake of calcium daily (in supplements or diet) _____

GYNECOLOGIC HISTORY

When was your last menstrual period? _____ At what age did your periods begin? _____
 How long between your periods? _____ How long do you flow? _____
 Do you have pain with your periods? _____ How severe? _____
 Do you have bleeding in between your periods? _____
 Do you have any pre-menstrual symptoms? _____
 Do you have symptoms of menopause? _____
 Are you sexually active? _____ Is/are your partner(s) male or female? _____
 Do you have pain or bleeding with intercourse? _____
 Do you have sexual difficulty/discomfort in your relationship? _____
 Have you ever been abused, threatened, or hurt by anyone? _____
 When was your last Pap smear? _____ Where was it done? _____
 Have you ever had an abnormal Pap smear? _____ When? _____ Result? _____
 If so, what was the method of treatment? _____
 Have you ever been treated for:
 _____ vaginal infection _____ herpes _____ genital warts _____ chlamydia _____ other infections?
 Would you like sexually transmitted disease testing today? _____
 Have you ever had fibroid tumors? _____ Ovarian cysts? _____
 Did your mother take DES when she was pregnant? _____

CONTRACEPTIVE HISTORY

Please check any method of birth control you have used in the past:

_____ Birth Control Pills _____ Depo Provera _____ Diaphragm/Cervical Cap _____ Intrauterine Device
 _____ Sponge _____ Foam _____ Condom _____ Withdrawal _____ Rhythm _____ Tubal Ligation
 _____ Vasectomy _____ Other: _____

Which method(s) do you now use? _____

Have you had problems with any of these methods? _____

Name: _____ DOB: _____

REPRODUCTIVE HISTORY

How many times have you been pregnant? _____

Have you ever had a (please give the year):

Miscarriage _____ Abortion _____ Ectopic/tubal pregnancy _____

Stillborn _____ Premature birth _____

Births (mo/yr)	Sex	Type of Delivery	Complications (y/n)	Name
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

Have you ever been concerned about infertility? _____

Have you ever been tested for infertility? _____

Have you become an adoptive parent? _____

HEALTH MAINTENANCE

When was your last mammogram? _____ Results? _____

When was your last bone density test? _____ Results? _____

When was your last cholesterol test? _____ Results? _____

When was your last colon cancer screen? _____ Results? _____

What is your primary reason/concern/request for this visit?