Client History

Thank you for taking the time to complete our paperwork. We acknowledge that it will take a bit of time — so sit down, pour yourself a cup of tea, and pull out your favorite pen! The information you provide will help us get to know you and individualize your care. Please complete prior to your first appointment.

Demographics

Your Full Name

Date of Birth | Age

Address

City | State | Zip

Mobile Number | Home Number

Email | Social Security Number

Race/Ethnicity | Primary Language

Marital Status ☐ Married ☐ Partnered ☐ Single ☐ Widowed

Emergency Contact Person | Emergency Contact Phone Number

Employer | Type of Work

Work Phone Number

Insurance

Primary Insurance

Billing Address

Phone Number | Policy Number | Group Number

Policy Holder's Name | Date of Birth

Secondary Insurance

Billing Address

Phone Number | Policy Number | Group Number

Policy Holder's Name | Date of Birth

Authorization to provide medical information via:

Phone Number | Email

Signature

What brought you to the birth center?

How did you hear about us ☐ Friend ☐ Referral ☐ Google ☐ Other

Boulder Community Health
THE BIRTH CENTER OF BOULDER

2800 Folsom Street, Boulder, CO 80304
303-443-3993 • bch.org/bcob

Social history

Your level of education ☐ High School ☐ Some College ☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctoral Degree

What is your occupation? If you are now staying home with your children, what work did you do previously?

How much do you work? Full Time. Part Time. Days. Nights.

What kind of relationship do you have?

- ☐ Long-term relationship with one partner.
- ☐ More than one partner in past year.
- ☐ No current partner.

How safe do you feel in your home?

- ☐ Very safe. No concerns with domestic violence.
- ☐ Safe now, but have had concerns with domestic violence in the past.
- ☐ I do not feel safe at home.

Have you ever or are you currently feeling abused physically, emotionally, sexually, or financially?

- ☐ Never.
- ☐ I have felt abused in the past but not currently.
- ☐ Yes, I am currently feeling abused.

Activity/rest

How often do you exercise? ☐ None ☐ Daily ☐ 3-5 days/week ☐ 1-2 days/week

Do you have any physical limitations? ☐ Yes ☐ No

What types of exercise do you enjoy?

How hours of sleep do you get per night? ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10+

Do you have any trouble sleeping? ☐ Yes ☐ No

If yes, please elaborate:

Caffeine, alcohol and drugs

How many 8 oz. servings of caffeine do you drink per day? ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4+

What kind? ☐ Coffee ☐ Tea ☐ Soda

How many alcoholic drinks have you had per week over the past 3 months? None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+

What kind? ☐ Wine ☐ Beer ☐ Liquor

Has anyone close to you complained about your drinking in the past year? ☐ Yes ☐ No

Do the drinking habits of anyone in your household worry you? ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ Never

If yes, in the past. When did you quit and how much did you smoke?

If yes, currently. How many cigarettes per day? Do you want to quit? ☐ Yes ☐ No

Have you ever used the following drugs: Marijuana, Cocaine, LSD, Heroine, Methamphetamines, Ecstasy?

- ☐ Never
- ☐ In past. What type and how much/how often?
- ☐ Currently. What type and how much/how often?

Does anyone in your household use drugs? ☐ Yes ☐ No

If yes, what type and how much/how often?

Do you take prescription pain medications? ☐ Yes ☐ No

If yes, what type and how much/how often?

Resource/needs assessment

What type of housing do you currently live in? ☐ Home ☐ Apartment/Condo ☐ Trailer

Do you feel it is adequate for your needs? ☐ Yes ☐ No

Do you receive food program assistance (WIC or food stamps)? ☐ Yes ☐ No

How often do you use a seatbelt when driving? ☐ Always ☐ Often ☐ Never

Do you have difficulty with reading, seeing, hearing, or following instructions? ☐ Yes ☐ No

Do you have other needs you need help with? ☐ Yes ☐ No

If yes, please elaborate:

Nutritional history

Do you follow any special diet? ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Paleo ☐ No ☐ Other

If other, please specify

Do you have any food allergies or intolerances? ☐ Yes ☐ No

If yes, please specify

How many times do you eat per day? Meals Snacks

How many servings of protein per day? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4+

What types of protein? ☐ Meat ☐ Eggs ☐ Beans ☐ Tofu ☐ Nuts

How many servings per day?

Vegetables: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4+

Fruit: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4+

Grains: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4+

Dairy: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4+

Sweets: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4+

Liters of Fluids: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+

Gynecological history

When was your last menstrual period?

Tell us about your typical menstrual pattern

How old were you got your first period?

How regular are your cycles? ☐ <28 days ☐ 28-30 days ☐ >30 days ☐ Irregular

Duration of flow? ☐ 2-3 days ☐ 3-5 days ☐ 5-7 days

Amount? ☐ Heavy ☐ Normal ☐ Light

Character? ☐ Painless ☐ Clots ☐ Cramping ☐ Other

Do you experience PMS symptoms? ☐ Yes ☐ No

If yes, describe

Who do you have sex with? ☐ Men only ☐ Men and Women ☐ Women only

Are you satisfied with sex? ☐ Yes ☐ No

If no, please elaborate

Do you experience any pain with sex? ☐ Yes ☐ No

When was the date of your last pap? Was it normal? ☐ Yes ☐ No

If 40 or older, have you had a baseline mammogram? ☐ Yes ☐ No ☐ N/A

Contraception

What birth control have you used in the past? For how long? Were you satisfied with the method?

☐ Oral Contraceptives For how long? Satisfied with method? ☐ Yes ☐ No

☐ Condoms For how long? Satisfied with method? ☐ Yes ☐ No

☐ Withdrawal For how long? Satisfied with method? ☐ Yes ☐ No

☐ Natural Family Planning For how long? Satisfied with method? ☐ Yes ☐ No

☐ ParaGard For how long? Satisfied with method? ☐ Yes ☐ No

☐ Mirena/Skyla/Kylee For how long? Satisfied with method? ☐ Yes ☐ No

☐ Diaphragm/Cervical Cap For how long? Satisfied with method? ☐ Yes ☐ No

☐ DepoProvera For how long? Satisfied with method? ☐ Yes ☐ No

☐ NuvaRing For how long? Satisfied with method? ☐ Yes ☐ No

☐ Nexplanon/Implanon For how long? Satisfied with method? ☐ Yes ☐ No

☐ Vasectomy For how long? Satisfied with method? ☐ Yes ☐ No

☐ N/A: Same Sex Relationship

Pregnancy history

Total Pregnancies (including current): Full Term Births: Preterm Births:

Twin/Multiple Births: Ectopic Pregnancies: Miscarriages:

Therapeutic or Induced Abortions: Living Children:

List All Pregnancies from first to last, including miscarriages or abortions:

Date	# Weeks	Type of Birth	Gender	Hours of Labor	Weight	Place of Birth	Pain Management	Child's Name

Gynecologic disorders

Note the date(s) that you had any of the following.

- ☐ I Have No History of Gynecological Problems
- ☐ Abnormal Mammogram
- ☐ Abnormal Paps
- ☐ Cryo / LEEP / Conization of the Cervix
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Genital Warts
- ☐ Genital Herpes
- ☐ Gonorrhea or Chlamydia
- ☐ Infertility
- ☐ Ovarian Cysts
- ☐ Pelvic Inflammatory Disease
- ☐ Trichomoniasis or Syphilis
- ☐ Uterine Abnormalitis
- ☐ Vaginal Infections: Yeast, Bacterial Vaginosis
- ☐ Other

Allergies

Please list any allergies you have (medications, iodine, shellfish, tape, and seasonal allergies) and the reaction.

- ☐ I Have No Known Drug Allergies

Medical history

Height Weight

Date of last Tetanus/Diptheria/Pertussis (TDAP) booster:

Date of last Flu shot:

When was your last visit to the dentist?

Personal history

Please indicate dates of applicable items.

- ☐ I Have No Personal History of Medical Problems
- ☐ Anemia
- ☐ Anxiety/Depression/Mental Illness
- ☐ Postpartum Anxiety/Depression
- ☐ Autoimmune Disorders: Lupus, MS
- ☐ Bleeding Disorders
- ☐ Blood Clots
- ☐ Cancer
- ☐ Diabetes: Type 1, 2, or Gestational
- ☐ Eating Disorder: Anorexia, Bulimia
- ☐ Headaches/Migraines
- ☐ Heart Disease
- ☐ High Blood Pressure: Chronic or in Pregnancy
- ☐ Intestinal Disease: Crohns, IBS
- ☐ Kidney or Bladder Infections
- ☐ Liver Disease: Hepatitis
- ☐ Lung Disease: Asthma, Tuberculosis, Pneumonia
- ☐ Periodontal Disease
- ☐ Rh negative blood type
- ☐ Seizures
- ☐ Thyroid Dysfunction
- ☐ Varicose Veins
- ☐ Other

Supplements or herbs

Please list all supplements/herbs you are taking, brand and dosage.

- ☐ I am not taking any supplements or herbs

Medications

Please list all medications / dosage / reason and for how long you have been taking.

☐ I am not taking any medications

Hospitalization and surgical history

List all past hospitalizations/surgeries other than childbirth: Dates, Reason, Complications

☐ I have not had any past hospitalizations or surgeries

Have you ever had any complications with anesthesia? ☐ Yes ☐ No

If yes, please list.

Have you ever received a blood transfusion? ☐ Yes ☐ No

If yes, when and why?

In the event of an emergency would you accept blood products? ☐ Yes ☐ No

Do you have an Advanced Directive on file? ☐ Yes ☐ No

Do you have a Power of Attorney on file? ☐ Yes ☐ No

Family medical history

Mother: ☐ Living. How is her health?

☐ Deceased. Age and cause of death

Father: ☐ Living. How is his health?

☐ Deceased. Age and cause of death

Number of sisters living How is their health?

Number of sisters deceased Age(s) and cause of death

Number of brothers living How is their health?

Number of brothers deceased Age(s) and cause of death

Does anyone in your family have a history of the following? List relation.

☐ No Family History of Medical Problems
☐ Cancer
☐ Anxiety/Depression/Mental Illness
☐ Diabetes
☐ Heart Disease
☐ High Blood Pressure
☐ Hepatitis/ Liver Disease
☐ Kidney Disease
☐ Thyroid Disease
☐ Other

Hereditary breast and ovarian cancer screen.

- ☐ Yes ☐ No You or a family member (mother or fathers side) were diagnosed with breast cancer at age 50 or younger.
- ☐ Yes ☐ No You or a family member were diagnosed with ovarian cancer at any age.
- ☐ Yes ☐ No Male family member with breast cancer at any age.
- ☐ Yes ☐ No Ashkenazi Jewish ancestry and a personal or family history of breast or ovarian cancer at any age.
- ☐ Yes ☐ No There are two breast cancers in the same person or two family members with breast cancer on the same side of the family, one under age 50.
- ☐ Yes ☐ No Family member was diagnosed with triple negative breast cancer at any age.
- ☐ Yes ☐ No There is a pancreatic cancer and a breast or ovarian cancer in the same person or on the same side of the family at any age.
- ☐ Yes ☐ No There are three family members with breast cancer in the same side of the family.
- ☐ Yes ☐ No You have a previously identified BRCA1 or BRCA2 mutation in your family.

Current health concerns. Review of systems.

Consider how you are feeling TODAY. If you are not experiencing any of the symptoms below, please initial the negative box.

General:

☐ Negative = no recent change in health or weight, fever, headaches, fatigue, weakness.

Head, eyes, ears, nose, and throat:

☐ Negative = no vision changes, hearing loss, allergies, nosebleeds, sore throat.

Breast:

☐ Negative = no breast lump or pain, tenderness, nipple discharge.

Cardiac:

☐ Negative = no chest pain, palpitations, varicose veins.

Respiratory:

☐ Negative = Denies chronic cough, coughing up blood, shortness of breath.

Gastrointestinal:

☐ Negative = Denies heartburn, nausea/vomiting, constipation, abdominal or pelvic pain.

Genitourinary:

☐ Negative = Denies painful urination, vaginal bleeding or discharge, painful sex.

Musculoskeletal:

☐ Negative = Denies joint swelling, muscle pain, leg pain or cramping, swelling, back pain.

Integumentary:

☐ Negative = Denies skin rash or itching, dry skin, moles, change in skin color.

Neurological:

☐ Negative = Denies dizziness, light headed, seizures, numbness, paralysis, vision changes.

Psychiatric:

☐ Negative = Denies anxiety, depression, memory loss, difficulty sleeping.

Endocrine:

☐ Negative = Denies excess thirst or urination, heat or cold intolerance.

Hematologic/ Lymphatic:

☐ Negative = Denies bleeding or bruising tendency, anemia, enlarged glands.

Primary care and alternative therapies

Who is your primary care physician? Phone Number

When was your last physical exam?

Who is your children's pediatrician? ☐ N/A or

Acupuncturist

Chiropractor

Massage Therapist

Physical Therapist

Psychotherapist

Other Practitioner

Signature

My signature confirms that the information provided is correct as far as I know.

Signature: Date

Thank you for taking the time to share with us your history.

For office staff only

Client History Reviewed by: Date

Release of Records completed for: