Dear Valued Patient,

Welcome to Aguirre Specialty Care (ASC). We are pleased that you have chosen us to evaluate your condition.

To facilitate your visit and ensure that ASC will be able to help you, we ask that you complete and return the 3 documents below *within 48 hours* of making your appointment. **These forms are necessary to confirm your appointment.** If you do not return these forms within 48 hours, your appointment may need to be rescheduled and or cancelled. You may choose to return the information by fax, mail or secure email. Dr. Aguirre will personally review this information to make sure that he has everything necessary to provide a comprehensive consultation on the day of your visit.

Patient Information Form
New Patient Questionnaire
Authorization to Receive Medical Records

Please complete the 2 forms below and bring them with you *at the time* of your appointment. If you have questions or concerns after reviewing our policies please do not hesitate to call our business office to discuss **prior to your appointment**. There is limited time on the day of your appointment to discuss any concerns regarding our policies. Additionally, our business personnel may not be available at the time of your appointment. If you arrive 15 minutes late or if your forms aren't completed and signed your appointment will be rescheduled.

Payment Terms and Agreements
Credit Card Consent

At your initial appointment, your medical history will be taken followed by a detailed pelvic examination. This will determine the need for diagnostic testing which will be scheduled accordingly.

Again, please do not hesitate to call our office with any questions or concerns you may have regarding your appointment. We look forward to meeting you.

Sincerely,

Dr. Aguirre and Staff

Aguirre Specialty Care

Oscar A. Aguirre, M.D., Director
9800 Mt. Pyramid Court, Suite #300
Englewood, CO 80112
Phone (303) 322-0500
Fax (303) 322-0772

New Patient Questionnaire

IMPORTANT: Please complete this questionnaire carefully and return to our office within 48 hours of scheduling your appointment. You may return it by fax, mail or secure email to confirm your appointment.

Date of Visit:_______/_______/_______

Name: ____ Date of Birth:_______/_______/_______ Age:_________

CHIEF COMPLAINT

Please briefly describe the reason(s) that you are being seen in our office:

____
____
____

For how long have you experienced each problem?

____
____
____

Please list any previous tests or treatments for each condition:

____
____
____

PAST MEDICAL HISTORY

Have you ever had any of the following problems? Please circle Yes or No:

		Explain:
Yes / No	Bleeding problems (blood clots, anemia, past transfusions)	______________
Yes / No	Cancer	______________
Yes / No	Diabetes	______________
Yes / No	Eye disorder (glaucoma, chronic dryness)	______________
Yes / No	Neurological problems (seizures, migraines, stroke, fibromyalgia)	______________
Yes / No	Gastrointestinal disorders (ulcers, reflux,)	______________
Yes / No	Heart problems (irregular heart beat, murmur)	______________
Yes / No	Hernia	______________
Yes / No	High blood pressure	______________
Yes / No	Kidney problems (stones, infection, decreased function)	______________
Yes / No	Liver problems	______________
Yes / No	Musculoskeletal problems (osteoarthritis, loose joints)	______________
Yes / No	Psychiatric problems (depression, anxiety, bipolar disorder)	______________
Yes / No	Respiratory problems (asthma, COPD, emphysema, sleep apnea)	______________
Yes / No	Skin disorder	______________
Yes / No	Spine injury	______________
Yes / No	Thyroid disease	______________
Yes / No	Other:	______________

REVIEW OF SYSTEMS

Check any conditions present today:

□ I have none of these problems today

Constitutional	HEENT	Cardiovascular	Respiratory
□ Recent weight change	□ Visual problems	□ Chest pain	□ Chronic cough
□ Fever	□ Hearing problems	□ Varicose veins	□ Wheezing
□ Weakness	□ Dry mouth	□ Blood clots	□ Oxygen use
□ Other________________	□ Other________________	□ Other________________	□ Other________________

Gastrointestinal	Musculoskeletal	Neurological	Skin
□ Heartburn	□ Muscle pain	□ Paralysis	□ Rashes
□ Nausea/Vomiting	□ Joint pain	□ Numbness	□ Sores
□ Hemorrhoids	□ Limited mobility	□ Tingling	□ Lumps
□ Other________________	□ Other________________	□ Other________________	□ Other________________

Endocrine	Hematological	Immunologic	Psychiatric
□ Hot flashes	□ Easy bruising	□ Swollen lymph nodes	□ Depression
□ Excessive thirst	□ Other________________	□ Other________________	□ Anxiety
□ Other________________			□ Other________________

OBSTETRICAL HISTORY

□ Skip this section. I have never been pregnant.

Number of pregnancies:__________ Miscarriages:_________ Abortions:__________ Living Children:_________

Date:	Weight:	Type of Delivery:			3rd / 4th Degree Tears:
_____________	_____________	□ vaginal	□ vaginal with forceps/vacuum	□ C-section	Yes / No
_____________	_____________	□ vaginal	□ vaginal with forceps/vacuum	□ C-section	Yes / No
_____________	_____________	□ vaginal	□ vaginal with forceps/vacuum	□ C-section	Yes / No
_____________	_____________	□ vaginal	□ vaginal with forceps/vacuum	□ C-section	Yes / No
_____________	_____________	□ vaginal	□ vaginal with forceps/vacuum	□ C-section	Yes / No
____________	_____________	□ vaginal	□ vaginal with forceps/vacuum	□ C-section	Yes / No

GYNECOLOGICAL HISTORY

Do you have menstrual periods? □ Yes □ No (skip to next question)

First day of last period: ______/______/______

Age at first period_________ Number of days between periods_________Duration of bleeding:_________

Do you bleed between periods? □ Yes □ No

Do you have heavy periods? □ Yes □ No

Do you have a need for birth control? □ Yes □ No (skip to next question)

What method of birth control are you and your partner using?____________________________________

Would you like to discuss a permanent method of birth control? □ No □ Yes

Have you gone through natural menopause? □ No □ Yes If yes, at what age? _______________

Have you had a hysterectomy? □ No □ Yes

If yes, □ abdominal □ vaginal Reason for hysterectomy________________________________

Were your ovaries removed? □ No □ Yes If yes, which ovary(ies)? □ left □ right □ both

Date of last pap smear ______/______/______ Normal? Yes / No Have you ever had an abnormal pap? Yes / No

Date of last mammogram______/______/______ Normal? Yes / No

Have you had a sexually transmitted disease? □ No □ Yes If yes, please list:__________________________

Name: ____ date:_____________________________

SURGICAL HISTORY

□ Skip this section. I have never had any type of surgery.

List ALL surgeries with the date, if possible. Include abdominal and plastic surgeries

____ ____
____ ____
____ ____
____ ____
____ ____

MEDICATIONS

□ Skip this section. I do not take any medications.

List all of the medications that you currently take, including over-the-counter medications and herbal supplements. List the dosage and how often you take it.

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

ALLERGIES

□ Skip this section. I have no known allergies.

List any allergies along with the type of reaction you experience.

____ ____
____ ____
____ ____

SOCIAL HISTORY

Marital status:	□ Single	□ Married	□ Divorced	□ Separated	□ Widowed	
Living situation:	□ Alone	□ Family	□ Skilled nursing facility/nursing home			□ Other
Tobacco use:	□ Yes □ No	Daily amount______________________________ Number of years______________				
Alcohol use:	□ Yes □ No	Daily amount____				
Street drug use:	□ Yes □ No	Type and daily amount____				
Caffeine use:	□ Yes □ No	Type and daily amount____				
Abuse:	□ Yes □ No	Describe____				
Exercise:	□ Yes □ No	Type and how often____				

FAMILY MEDICAL HISTORY

Please circle Yes or No:

		Relationship:
Yes / No	Bleeding disorder	____
Yes / No	Cancer (list type)	____
Yes / No	Diabetes	____
Yes / No	Heart disease	____
Yes / No	Hernia or vaginal prolapse	____
Yes / No	Urinary problems	____
Yes / No	Other:	____

Name: ____ date:____________________________

UROGYNECOLOGIC QUESTIONNAIRE

I urinate every ______ hours during the day.
At night, I get up ______ times to urinate.

Question	Response
Do you lose urine in spurts with laughing, sneezing, or exertion?......................	Yes No
What amount of urine do you lose?..	Small Large Both
In what position do you lose urine?..	Sitting Standing Lying down
Do you lose urine with a strong sense of urgency?..	Yes No
Does the sound, sight, or feel of running water make you lose urine?.......	Yes No
Do you lose urine without any warning (without activity or urgency)?..............	Yes No
Do you wear a pad all of the time?..	Yes No
Is it difficult to get the urine stream started?...	Yes No
Does your urine stream seem slow or weak?...	Yes No
Do you feel that you empty your bladder completely when you urinate?	Yes No
Do you have pain associated with urination?..	Yes No
Do you have frequent bladder infections?...	Yes No
Do you feel as if your pelvic organs are "falling down"?.................................	Yes No
Do you feel a bulge at the opening of your vagina?................................	Yes No

BOWEL FUNCTION QUESTIONNAIRE

□ Skip this section. I have no problems with my bowel function.

I move my bowels ______ times per day or ______ times per week.

Question	Response
Do you have difficulty emptying your rectum?...	Yes No
What is the consistency of your stool when this happens?........................	Liquid Soft Normal Hard
Does it help to press on the inside or outside of the vagina?.....................	Yes No
Do you lose control of stool?...	Yes No
What is the consistency of your stool when this happens?........................	Liquid Soft Normal Hard
Do you have problems controlling gas?...	Yes No
Do you have alternating constipation and diarrhea?...	Yes No
Do you have pain with bowel movements?...	Yes No
Do you ever see blood in your stools?..	Yes No

COSMETIC GYNECOLOGY QUESTIONNAIRE

□ Skip this section. I have no problems with the appearance or function of my genital region

Question	Response
I am self-conscious about the appearance of my vulva/vagina………………….	Yes No
I am unhappy with the way my vagina looks (i.e. gaping)……………………...	Yes No
I am unhappy with the way my labia look (irregular, dark, long)………………	Yes No
My labia rub or pull on my clothing or during sex…………………………...	Yes No
I am unable to wear the type of clothing that I want…………………………….	Yes No
My vagina feels loose during sex………………………………………………	Yes No
I have decreased sensation during sex…………………………………………..	Yes No
I wish to enhance my pleasure with sex…………………………………………	Yes No
I want cosmetic vaginal surgery…………………………………………………	Yes No

SEXUAL FUNCTION QUESTIONNAIRE

□ Skip this section. I do not have any problems with my sexual functioning.

Sexual orientation: □ heterosexual □ homosexual □ bisexual

Question	Response
I have low desire to participate in sexual activity……………………………….	Yes No
I am unable to reach orgasm ……………………………………………………	Yes No
I have significant difficulty reaching orgasm…………………………………..	Yes No
I have a difficult time becoming aroused during sexual activity……………….	Yes No
I do not become sufficiently lubricated with sexual activity……………………	Yes No
I experience pain with vaginal penetration……………………………………...	Yes No

Name: ____ date:______________________

BODY CONTOURING QUESTIONNAIRE

Height__________ Current Weight_______ Goal Weight _______

Are you interested in Body Contouring?.. Yes No

I have tried exercise and diet, but can not get rid of the unwanted fat………… Yes No
I am unhappy with the appearance of my abdomen………………….................. Yes No
I am unhappy with the appearance of my legs……………………................... Yes No
I am unhappy with the appearance of my arms………………………………… Yes No
I dislike the appearance of fat when wearing a bra……………………………... Yes No
I am unhappy with the appearance of my pubic area/ labia majora ………... Yes No

DERMAL AESTHETIC QUESTIONNAIRE

Do you have any concerns with the appearance of your skin?......................... Yes No

Do you have any issues with Spider veins/varicose veins…………………… Yes No
Do you have any Anti aging skin care concerns……………………………… Yes No
Do you want to learn more about Skin care products………………………… Yes No
Do you have any issues with wrinkles or fine lines…………………………... Yes No
Do you have any issues with Sun spots/Age spots…………………………… Yes No
Do you have any concern with Aging/dull looking skin……………………... Yes No
Do you have any issues with Large pores/Scars/Skin texture………………... Yes No
Do you have any concern with Flushing of the skin/Redness………………... Yes No
Do you have an interest in Laser Hair Removal……………………………… Yes No
If Yes, what areas: ___________________________________

WEIGHT LOSS QUESTIONNAIRE

Are you interested in a weight loss option? ………………..………………………Yes No

Have you tried any weight loss programs in the past?..Yes No

If Yes, which ones have you tried? ____

For Office Use Only

Notes: ____

____

____

____

Name: ____ date:___________________________