Dr. Cynthia Barco

3-1153 Esquimalt Road, Victoria, BC, V9A 3N7 Phone: (778) 265-4305 Fax: (778) 265-4306

New Patient Intake Form

Name _____ Age: _____
Date of Birth (d/m/y) _____ Gender: M / F MSP # _____
Phone # _____ Alt. # _____
Email Address _____
Address _____

_____
Emergency Contact _____ Ph. # _____

Dear Patient,

Welcome to my practice. Currently, I am a part-time practitioner working mostly on Mondays, Thursdays and Fridays. Our clinic also offers a full-time walk-in clinic for more immediate concerns if you are unable to access my care urgently. Please be aware that my availability may be subject to change.
Our physicians and staff maintain an attitude of respect, which we kindly ask you to return.
It is important to identify myself as your family doctor to others who may be involved with your care. This is so that important information regarding your health is communicated to me in a timely fashion.
Certain medications require extra care and monitoring. These include narcotics and other medications with a potential to develop dependency. Should you require these medications, you will be asked to agree to certain conditions before they are prescribed.
Unfortunately, I do not refill medications over the phone. If you are out of medication, this is because it is time for it to be re-evaluated.
I do NOT prescribe any methods of artificial birth control. These include all forms of hormonal birth control and IUDs. I do not refer for abortions. I do support Natural Family Planning and have a special interest in cooperative Women's health and infertility. I do work with professionally trained practitioners who teach women/couples to chart their symptoms of fertility to use for family planning. Using these charts and timed hormonal testing as well as other needed tests, I can work at diagnosing and treating reproductive disorders.
I will continue to care for all of your health needs and gynecologic issues including Pap smears, pregnancy planning, menstrual irregularities, infections, pelvic pain, menopause, infertility etc. I will continue to offer you, to the best of my ability, all of the information available regarding your fertility options so that you can make your own informed decision about your health choices. If you do need or desire any of the services that I do not offer, the Walk-in-Clinic at this clinic will provide them to you in a timely manner.
If you would like any more information or would like to discuss these issues with me, you are welcome to make an appointment to do so at any time.
Thank you for involving me in your care.

With respect,
Dr. Cynthia Barco

CANCELLATION POLICY

Our office requires a minimum of 24 hours' notice if you need to cancel an appointment. If we are given less than 24-hours' notice, or if the appointment is missed, there will be a charge for the appointment, $40 for general appointment, $75 for physicals.

Please indicate below that you have read and understand the above information and thus agree to enter into my practice.

Name (please print) _____ Date _____

Signature _____

Medical Questionnaire:

Please identify the name of your previous family doctor, and your reason for seeking a new physician:

_____

Please identify any medical conditions which currently affect you:

_____
_____
_____
_____
_____
_____
_____
_____

Please identify any previous surgical procedures, and indicate their reason and year:

Procedure: _____
Reason: _____
Year: _____

Procedure: _____
Reason: _____
Year: _____

Procedure: _____
Reason: _____
Year: _____

Others:

_____
_____

Please identify any previous admissions to hospital, and their year:

_____
_____
_____

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Please identify any specialist physicians involved in your care:

Please identify any other practitioners involved with your care (example- physiotherapists, naturopathic doctors, chiropractor, etc.)

Please identify any current or past Mental Health problems or conditions you have experienced or are experiencing presently (i.e.: PTSD, Post-Partum, Depression, Anxiety etc.):

Please identify all prescription medications, over the counter medications, herbal medications and vitamins that you take on a regular basis.

_____
_____

Please identify any adverse reactions or allergies you have to medications or other substances.

_____
_____
_____
_____

Please describe your family history:

Mother:
Alive ____ Deceased ____ Medical illnesses:_____
_____
Father:
Alive ____ Deceased ____ Medical illnesses:_____
_____

Siblings and any major illnesses:
_____
_____
_____

Children, age, and any major illnesses:
_____
_____

In the extended family- any cancer, diabetes, heart disease, stroke or genetic conditions
_____
_____
_____

Do you smoke? If so, indicate when you started and how many per day:
_____

Have you tried to quit? If so, what methods have you tried:
_____

Have you smoked in the past? If so, how much and when did you start and quit:
_____

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Have you had significant exposure to second hand smoke? Yes/ No/ Unsure

Please indicate which option below best describes your alcohol intake:

Never _____ Occasionally (example: holidays) _____
Less than 1 drink/week _____ 1-5 drinks/week _____
5-10 drinks/week _____ +10 drinks/week_____ Indicate amount _____

Do you sometimes drink >4 alcoholic drinks on one occasion? Y / N

In the past, did you ever consume alcohol more regularly than you do currently?
_____

Please indicate any current or past recreational drug use

_____
_____

Please indicate which option below best describes your exercise habits (outside of work):

Never _____ Less than 30 minutes per week _____ 30-60 minutes per week _____
1-2 hours per week _____ More than 3 hours per week _____

Briefly describe what activities you participate in for exercise:
_____
_____

Please indicate your current relationship status (all that apply)

Married ____ Common-law ____ Single ____ Widowed ___ Divorced ____
Other romantic relationship ____

Please indicate your sexual orientation:
_____

Please indicate your occupation:
_____

Please briefly describe any stressful life events that are currently impacting your mental or physical health:

_____
_____
_____

Please indicate the date of your last full physical exam:
_____

Please indicate the last date of the following screening procedures if applicable:

Mammogram _____ Colonoscopy _____
FIT test (stool test for colon cancer screening) _____

Please indicate the year of the following vaccinations if known:

Tetanus shot _____Flu shot _____ Zoster (shingles) shot _____
Pneumovax (pneumonia) shot _____ Cervarix (*female only*) _____
Other (please specify) _____

Children only:

Vaccinations up to date: Y/N Prematurity: Y/N
Reaching developmental milestones: Y/N

Please indicate any other information you feel it is important for your doctor to know:

_____
_____
_____
_____

_____

Thank you!!

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Date:_____

Dear Dr._____

Ph:_____ Fax: _____

Re: Patient_____

Date of Birth_____

Address: _____

_____

The above patient has come under my care and I would greatly appreciate it if you could send me a COPY of the patient's medical records. Please send relevant and recent medical records that will assist in the care of this patient. Please do not send the whole chart. Consult and imaging reports are appreciated as well as chart summaries. Encounter notes and lab results are only useful if done within the last year.

Thank you very much for your prompt reply.
Kindest Regards,

_____

Dr. Cynthia Barco

I consent to the release of the above information to Dr. Cynthia Barco (22755), and I understand this service is NOT covered by my insurance. Upon receiving a bill, I agree to pay the requisitioned doctor a reasonable fee for this service.

Signed:_____ Date:_____

Please DO NOT SEND original documents. Esquimalt Medical Clinic has an entirely electronic medical record system (profile). Some, but not all, of the information you supply will be scanned into our computer record before shredding. Esquimalt Medical Clinic cannot accept any responsibility for `safe keeping` of any original medical documents or consequences and liabilities resulting from loss of original documents if they are sent to us.

Please DO NOT fax records exceeding 20 pages. Thank you!

Women only:

Menstrual History

At what age did you have your first menstrual period? _____ (Age)
On average, how many days of menstrual bleeding do you have? 1-2 3-4 5-6 7-8 9 or more
In the last year, what is the shortest menstrual cycle you have had (number of days from the beginning of one menstrual period to the next menstrual period)?
_____ number of days
In the last year, what is the longest menstrual cycle you have had (number of days from the beginning of one menstrual period to the next menstrual period)?
_____ number of days
What is the beginning date of your last menstrual period?
|___|___| / ___|___|___| / ___|___|___|___| (example: 17 / Mar / 2005)
Day / Month / Year

How would you describe your cycles currently?
Regular Irregular Both Other (describe): _____

Have your menstrual cycles ever stopped for any reason? Yes/ No/ Unsure
If yes or unsure, please explain:
_____

Do you usually have any kind of symptoms for 4 or more days before your menstrual bleeding starts? Yes/ No/ Unsure
®If no symptoms experienced for 4 or more days, skip
Please indicate which of the following symptoms you have for 4 or more days before your menstrual bleeding starts: (Please mark all that apply)
Irritability/ Insomnia/ Bloating/ Weight gain/Salt,sweet cravings/ Cry easily/ Depression/ Headache/ Fatigue/ Breast tenderness/ Loss of control/ Feeling "wired"
Other (describe): _____
Referring to all the symptoms marked, on the whole, how severe would you rate these symptoms? (Please mark one) Minimal 1 2 3 4 5 6 7 8 9 10 Extreme
Are these symptoms relieved with menstruation? Yes/ No/Unsure

How painful are your menstrual periods? (Please mark one)
Minimal 1 2 3 4 5 6 7 8 9 10 Extreme

Do you suffer from constipation and/or diarrhea at the time of your period?
Yes/ No/ Unsure

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Gynecologic History (Female Sexual Health)

Have you ever had any gynecologic infections? Yes/ No/ Unsure
Have you ever had symptoms of menopause such as hot flushes? Yes/ No/ Unsure
Have you ever had irregular bleeding from the vagina or uterus? Yes/ No/ Unsure
Have you ever had ovarian cysts? Yes/ No/ Unsure
What is the month and year of your last Pap smear?
_____Month _____Year
Have you ever had an abnormal Pap smear? Yes/ No/ Unsure
®If no, skip
If yes or unsure, what kind of abnormality(ies) were noted on your Pap smear?
(Please mark all that apply)
Inflammation/ Dysplasia/ Cancer/ Papilloma (wart) virus/Abnormal cells/ Unsure

Have you ever had surgery or freezing of the cervix (such as CRYO, laser, LEEP, hot cautery)? Yes/ No/ Unsure
If yes, which procedure(s)?
_____

What types of contraception or family planning methods have you used in the past and for how long?
_____
_____
_____
_____
_____

Number of previous pregnancies _____
Details of each pregnancy (miscarriage, abortion, vaginal or c-section delivery, complications etc.)
_____
_____
_____
_____
_____
_____