Capital Women's Care
Frederick OB/GYN Division

PATIENT HISTORY QUESTIONNAIRE

To help us know your medical history, please answer these questions and bring with you when you are called back by the Medical Assistant for your appointment

Name: ____ Date: ____________________________

Date of Birth: _________________________ Reason for visit: _____________________________________

Email address: _____________________________ Who Referred you to our practice ____________________

CWC Provider ____________________________ Primary Care Provider _______________________________

Allergies/Reaction: ____

____

Latex Allergy? Yes ___No ___Pharmacy Name: ___________________ Address: ____________________________

Current Medications: ____

____

Age of first menstrual period: ___________ Last menstrual period: _________________________________

Date of last Annual Exam: _______________ Where? ____

Date of last Pap smear: __________________

Date of last mammogram: ______________ Where? ____

Current method of contraception: ____

Have You Had These Vaccines?		
☐ HPV Date: _____________	☐ Hepatitis B Date: ____________	☐ Tetanus Date: _____________

#of Pregnancies_____# of C-sections______# of miscarriages______# of abortions______# of live births______-

Number & Gender of Children: # of Boys______ # of Girls______ **Do you have an Advanced Directive: YES/NO**

Highest level of Education (Circle one): High School Some College College Grad Tech School Med School

Race: ______________________ Ethnicity (circle one): Latino non-latino Language: ______________________

Employer: ___________________________________ Occupation: ____

Medical History: Please check any that *you* have had.

_ Abnormal Pap
_ Anemia
_ Asthma
_ Autoimmune disease
_ Bartholin's gland cyst
_ Hx of blood transfusion
_ Breast Cancer
_ Breast Mass
_ Bruising/bleeding disorder
_ Stroke
_ Cervical Cancer
_ Congenital heart disease
_ Cystocele
_ Depression
_ DES exposure
_ Diabetes/Gestational
_ Drug/Alcohol abuse
_ Endometriosis
_ Fam hx of genetic disorder
_ Fetal death, prior
_ Fibroids in uterus
_ Gallbladder disease
_ Exposure to Herpes
_ Genital Herpes
_ Heart murmur
_ Hepatitis/Liver disease
_ Blood disorder
_ High Cholesterol
_ High Blood Pressure
_ Incompetent cervix
_ Infertility
_ Neonatal death, prior
_ Phlebitis
_ Obesity
_ Ovarian Cancer
_ Ovarian Cyst
_ PID
_ Polycystic ovaries
_ Premature rupture of membranes
_ Preterm delivery
_ Psychiatric disease
_ Pulmonary embolism
_ Recurrent miscarriages
_ Seizure disorder
_ Thyroid disease
_ Tuberculosis
_ Uterine Cancer
_ UTI, recurrent
_ Vaginal infections
_ STD
_ HIV/AIDS

Other: ____

Surgical History:

Date of surgery   Type of surgery

______________   ____
______________   ____
______________   ____

Family History:

Please indicate the family member by putting a check mark in the box. If the family member is someone other than those listed please indicate maternal or paternal (aunt, uncle, grandmother, or grandfather).

Diagnosis:	**Mother**	**Father**	**Sister**	**Brother**	**Son**	**Daughter**
Alive and Well						
Deceased (indicate cause)						
Alcoholism						
Asthma						
Autoimmune disorder						
Breast Cancer						
Cervical Cancer						
Coagulopathy (Blood clots)						
Colon Cancer						
Heart birth defect						
CAD/Heart attack						
Stroke						
Cystic Fibrosis						
Depression						
Developmental delay						
Diabetes						
Down’s Syndrome						
Hemophilia-A						
High Cholesterol						
High Blood Pressure						
Mental Illness						
Muscular dystrophy						
Osteoporosis						
Ovarian Cancer						
Seizure disorder						
Sickle cell disease						
Spina Bifida						
Thyroid disease						
Other						

Tobacco Use: _ Never _ Yes _ Former
Type: ______________________________
Packs per day: ______________________________
Years Smoked: ______________________________

Caffeine Use: _ No _ Yes
Type:______________________________
Amount per day:______________________________

Alcohol Use: _ No _ Yes _ Former
Type:__________________________
Amount:__________________________
Frequency:__________________________
Last Drink:__________________________

If updated please initial and date:

______________   ______________

Updated Form 1/2017