CAPITAL WOMEN'S CARE

PATIENT HISTORY FORM

Name _____

Date of Birth _____

Date of Visit _____

Age: _____ Marital Status: _____ Occupation: _____ Primary Care Provider: _____

Reason for your visit today: _____

_____

Current Contraception: ❑ None ❑ Natural Family Planning ❑ Diaphragm ❑ Condoms ❑ Birth Control Pills - Brand: _____
❑ Contraceptive Gel/Foam ❑ Patch ❑ Nuvaring® ❑ DepoProvera® ❑ IUD
❑ Tubal Ligation ❑ Essure® ❑ Nexplanon® ❑ Implanon® ❑ Vasectomy

If Postmenopausal, are you on Hormone Replacement Therapy? ❑ Yes ❑ No Have you ever been on HRT? ❑ Yes ❑ No

Medication Allergies: ❑ None ❑ _____

List all prescription medications you are currently using: ❑ None ❑ _____

_____

List all non-prescription medications or supplements you are currently using: ❑ None ❑ _____

_____

What was the first day of your last menstrual period? _____
When was your last mammogram? _____
Do you perform breast self-exams monthly? ..... ❑ Yes ❑ No
When was your last PAP test? _____
Do you have a history of Sexually Transmitted Disease? ... ❑ Yes ❑ No
Have you had 5 or more sexual partners? ..... ❑ Yes ❑ No
Was your age at first intercourse under 16? ..... ❑ Yes ❑ No
Were you exposed to DES before your birth? ..... ❑ Yes ❑ No
Have you ever had an abnormal PAP smear?..... ❑ Yes ❑ No

Do you exercise regularly? ..... ❑ Yes ❑ No
Do you use seat belts? ..... ❑ Yes ❑ No
Do you smoke? ..... ❑ Yes ❑ No
How much? _____
Do you drink alcohol? ..... ❑ Yes ❑ No
How much & how often? _____
Do you use any recreational drugs? ..... ❑ Yes ❑ No
What & how often? _____

_____

Surgeries or Hospitalizations: ❑ None

Type of surgery or reason for hospitalization	Date	Doctor	Hospital or Facility

Pregnancies (include losses and terminations) and adoptions

Year	Male/Female	Weight	Vaginal, C-Section or Adoption	Complications

Do you have or have you ever had…

Diabetes	❑	High blood pressure	❑	Chronic lung condition	❑	Osteoporosis	❑
Asthma	❑	Mitral valve prolapse	❑	Alcohol abuse	❑	High cholesterol	❑
Stroke	❑	Seizures/Epilepsy	❑	Drug/substance abuse	❑	Rheumatic fever	❑
Ulcers	❑	Tuberculosis	❑	Hepatitis/liver disorder/Jaundice	❑	Blood transfusion	❑
Heart disease	❑	Bowel trouble	❑	Blood clots in legs/lung/heart	❑	Transfusion reactions	❑
Chronic anemia	❑	Kidney stones	❑	Autoimmune diseases (lupus, etc.)	❑	Anesthetic reactions	❑
Thyroid disorder	❑	Bleeding disorder	❑	Depression, anxiety	❑	Eating disorder	❑

Cancer ❑ Yes ❑ No If yes, Type, Date and Treatment: _____
Other disease? _____

Please continue to page 2…

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PATIENT HISTORY FORM

PAGE 2

Name _____

Date of Birth _____

Date of Visit _____

Are you currently experiencing any of the following? (Please check all that apply.)

- ❑ Chills
- ❑ Fever
- ❑ Ear Infection
- ❑ Sore Throat
- ❑ Vision Changes
- ❑ Asthma
- ❑ Cough
- ❑ Shortness Of Breath
- ❑ Chest Pain
- ❑ Irregular Heart Beat
- ❑ Palpitations
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea or Vomiting
- ❑ Pain With Urination
- ❑ Frequent Urination
- ❑ Incontinence
- ❑ Change In Vaginal Discharge
- ❑ Vaginal Itching
- ❑ Sexual Problems
- ❑ Cold Intolerance
- ❑ Heat Intolerance
- ❑ Weight Change
- ❑ Anxiety
- ❑ Depression
- ❑ Headache
- ❑ Tremors
- ❑ Change In Color/Size Of Moles
- ❑ Rashes
- ❑ Hives
- ❑ Back Pain
- ❑ Joint Pain
- ❑ Muscle Aches
- ❑ Bleeding
- ❑ Easy Bruising
- ❑ Blood Clotting
- ❑ ***None Of The Above***

Please list any major illnesses that have occurred in your family. Is there a **family** history of…

Illness		Relationship	Illness		Relationship
Breast Cancer	❑		Thyroid disorder	❑	
Ovarian Cancer	❑		Coronary artery disease	❑	
Colon Cancer	❑		High cholesterol	❑	
Osteoporosis	❑		Stroke	❑	
Diabetes	❑		High blood pressure	❑	
Other:					

Additional Notes