CAPITAL WOMEN'S CARE

Returning Patient History Form

Name _____ Date of Visit _____

Date of Birth _____ Last Menstrual Period _____

Periods are regular ❑ irregular ❑ absent ❑

Pain with periods ❑ Heavy periods ❑

I have had an abnormal Pap smear in the past no ❑ yes ❑

Number of ***new*** sexual partners since your last visit _____

Contraception (please circle): none natural family planning diaphragm condoms birth control pills contraceptive gel/foam patch Nuvaring ® DepoProvera ® IUD tubal ligation Essure® Nexplanon® Implanon® vasectomy

Smoking no ❑ yes ❑ how much? _____ **Exercise** frequency _____ x per week

Current Medications ❑ none _____

_____

Supplements: Multivitamin ❑ Calcium ❑ Vitamin D ❑ Fish oil ❑ Folic Acid ❑

Allergies to medications _____

Any new medical conditions since your last visit here? _____

_____

Any new surgical procedures since your last visit here? _____

_____

Any new family history since your last visit here? _____

_____

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

- ❑ Chills
- ❑ Ear Infection
- ❑ Asthma
- ❑ Chest Pain
- ❑ Constipation
- ❑ Pain With Urination
- ❑ Change In Vaginal Discharge
- ❑ Cold Intolerance
- ❑ Anxiety
- ❑ Headache
- ❑ Change In Color/Size Of Moles
- ❑ Back Pain
- ❑ Abnormal Vaginal Bleeding
- ❑ Fever
- ❑ Sore Throat
- ❑ Cough
- ❑ Irregular Heart Beat
- ❑ Diarrhea
- ❑ Frequent Urination
- ❑ Vaginal Itching
- ❑ Heat Intolerance
- ❑ Depression
- ❑ Tremors
- ❑ Rashes
- ❑ Joint Pain
- ❑ Easy Bruising
- ❑ Abdominal Pain
- ❑ Vision Changes
- ❑ Shortness Of Breath
- ❑ Palpitations
- ❑ Nausea or Vomiting
- ❑ Incontinence
- ❑ Sexual Problems
- ❑ Weight Change
- ❑ Abdominal Pain
- ❑ Hives
- ❑ Muscle Aches
- ❑ Blood Clotting

❑ **None of the above**

_____