CAPITAL WOMEN'S CARE®
"Working Together for Women's Health"

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Laura A. Burnham, CRNP
Linda R. Follette, CRNP
Jamie Huppmann, CRNP

MRN:_____

(For Office Use)
P: ✓ ☺ 👎

Returning Patient History Form

Name_____ **Date**_____**Reason for Visit**_____

Date of Birth _____ **Last Menstrual Period** _____

Primary Care Provider_____**Pharmacy**_____

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 _____ Marital Status (Optional)_____

Contraception: _____

Deliveries (#) Vaginal__ C-Section__ Full-Term__ Pre-Term__ Miscarriages__ Ectopic__ Abortion__

Alcohol__ Type _____ Frequency_____ **Caffeine**__ Type_____ Frequency_____

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? _____ Reaction: _____
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 ❑ Diarrhea
❑ Pain With Urination
❑ Vaginal Discharge or Itching
❑ Cold Intolerance
❑ Anxiety
❑ Rash
❑ Back Pain
❑ Fever
❑ Sore Throat
❑ Cough
❑ Irregular Heart Beat
❑ Abdominal Pain
❑ Frequent Urination
❑ Abnormal Vaginal Bleeding
❑ Heat Intolerance
❑ Depression
❑ Hives
❑ Joint Pain
❑ Fatigue
❑ Vision Changes
❑ Shortness Of Breath
❑ Easy Bruising
❑ Nausea or Vomiting
❑ Incontinence
❑ Sexual Problems
❑ Weight Change
❑ Headache
❑ Muscle Aches

❑ **None of the above**

We want to know about your experience at our practice. Please provide your email address if you are

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willing to receive an email with a brief survey:

_____

_____ REV. 11/20