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

PATIENT HISTORY FORM

PAGE 1

Name_____
Date of Birth _____PN_____
Date of Visit _____

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

Pharmacy: _____ Reason for Visit: _____

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 currently 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 the age of 16? ..... ☐Yes ☐No
Were you exposed to DES (Diethylstilbestrol) before birth? ..... ☐Yes ☐No
Have you ever had an abnormal PAP smear? ..... ☐Yes ☐No

Do you exercise regularly? ..... ☐Yes ☐No
Do you use seatbelts? ..... ☐Yes ☐No
Do you smoke? ..... ☐Yes ☐No
How much? _____
Do you drink alcohol? ..... ☐Yes ☐No
How much and how often? _____
Do you use any recreational drugs? ..... ☐Yes ☐No
What kind and how often? _____
_____

Surgeries or Hospitalizations: ☐None

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

Pregnancies (inlcude losses or terminations) and adoptions: ☐None

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 ..... ☐	Hepatitus/Liver Disorder/Jaundice ..... ☐	Blood Tranfusion ..... ☐
Heart Disease ..... ☐	Bowel Trouble ..... ☐	Blood Clots in Legs/Lung/Heart ..... ☐	Transfusion Reactions ..... ☐
Chronic Anemia ..... ☐	Kidney Stones ..... ☐	Autoimmune Diseases (lupus, etc.) ..... ☐	Anesthestic 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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MRN _____

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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 the apply.)

☐Chills	☐Fever	☐Vision Changes
☐Ear Infection	☐Sore Throat	☐Shortness of Breath
☐Asthma	☐Cough	☐Palpitations
☐Chest Pain	☐Irregular Heartbeat	☐Nausea or Vomiting
☐Constipation	☐Diarrhea	☐Incontinence
☐Pain with Urination	☐Frequent Urination	☐Sexual Problems
☐Change in Vaginal Discharge	☐Vaginal Itching	☐Weight Change
☐Cold Intolerance	☐Heat Intolerance	☐Hives
☐Anxiety	☐Depression	☐Muscle Aches
☐Headache	☐Tremors	☐Blood Clotting
☐Change in Color/Size of Moles	☐Rashes	
☐Bleeding	☐Joint Pain	
☐***None of the Above***	☐Easy Bruising	

Please list any major illnesses that have occured in your family, and your relationship to the family member:

Illness	Relationship	Illness	Relationship
☐ Breast Cancer		☐ Thyroid Disorder	
☐ Ovarian Cancer		☐ Coronary Artery Disease	
☐ Colon Cancer		☐ High Cholesterol	
☐ Osteoporosis		☐ Stroke	
☐ Diabetes		☐ High Blood Pressure	

Additional Notes: