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

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PR:_____

Returning Patient History Form

Name _____ **Date** _____ **Date of Birth** _____

Reason for Visit _____ **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:

□ **None**	□ **Condoms**	□ **Tubal Ligation**	□ **Birth Control Pills** **Brand** _____	
□ **IUD**	□ **Vasectomy**	□ **Vaginal Ring**	□ **Nexplanon®**	□ **Depo Provera®**
□ **Natural Family Planning**	□ **Essure®**	□ **Hormone Patch**	□ **Gel/Foam**	□ **Diaphragm**

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

Year of most recent Colonoscopy:_____

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**