Capital Women's Care **Doctor_____**

Name _____ Age_____ DOB_____ Today's date _____

Cell Phone _____ Work Phone _____ Other_____ Occupation___
Email Address_____
Pharmacy & Address_____

Reason for Appointment: ( ) Annual routine; OR ( ) Other/problem: _____

I request these tests today: ( )Pap Smear. ( )STD test. ( )HIV test. ( )cholesterol.

( )other:_____

First day of last menstrual cycle _____
Do you currently need/use contraception? _____ If yes what? _____

My periods are: ( )regular. ( )irregular. ( )cramps. ( )abnormal bleeding. ( )other: _____

Please list all current medications: or if none please check here: ( )

Name	Dose	Directions	Reason	Prescriber

Supplements: ( )multivitamin. ( )calcium. ( )vitamin D. ( )other: _____

Please list any allergies: ( )none. ( )latex. ( )peanuts. ( )other:

Allergy	Reaction

Activity	Frequency	Amount
Tobacco/vaping: ( )never. ( )former. ( )current:		
Alcohol: ( )never. ( )former. ( )current:		

Patient updates since your last visit here in our office:

New personal updates _____

New family updates _____

Currently are you experiencing any problems in the following areas?

Issue	Yes	No	Issue	Yes	No
General Wellness			Muscle, joints, bones		
Eyes			Skin		
Ears, nose, throat			Neurologic		
Heart/circulation			Psychiatric		
Lungs/breathing			Endocrine		
Stomach/digestion			Blood/lymph		
Reproduction/urinary			Allergies		

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Returning patients please STOP here. New patients, please complete back of page.

Health Questionnaire for New Patients

Age of onset menstrual cycle _____ Days of bleeding _____ Issues _____

Date of last PAP test: _____Results:_____ Where?_____

Have all of your PAP tests been normal? _____

Surgery(ies): ( ) none; OR LIST ALL (include complications): _____

Hospitalizations: ( ) none; OR LIST ALL: _____

PERSONAL MEDICAL HISTORY:

Have you ever been diagnosed with:	**Yes**	**No**		**Yes**	**No**
Cancer/type			STD		
Diabetes			Seizure disorder		
Heart or lung disease			Thyroid disorder		
High blood pressure			DES exposure?		
Stroke			Skin problems		
Kidney or liver disease			Blood clot in lungs or legs		
Genetic Disease			HPV (Gardasil) vaccinations		
Migraine headaches			Gynecological disorder		
Infertility treatment/medication			Blood transfusion		
Other			Orthopedic problems		

FAMILY HISTORY

Has a family member ever been diagnosed with:	**Family Member**	**Alive? Comments:**
Cancer (list type):		
Diabetes		
Heart disease		
High blood pressure		
Stroke		
Kidney disease		
Blood clot in lungs or legs		
Genetic disease		
Mental Illness		
Osteoporosis		

OBSTETRICAL HISTORY (please include all pregnancies):

Year	**Vaginal or Cesarean & hours in labor**	**Weight of baby**	**Gender**	**Anesthesia?**	**Complications**