General Wellness Muscle, joints, bones Eyes Skin Ears, nose, throat Neurologic Heart/circulation Psychiatric Lungs/breathing Endocrine Stomach/digestion Blood/lymph	Name		Age	DOB	Today's da	te	
request these tests today: ()Pap Smear. ()STD test. ()HIV test. ()cholesterol.)other: irst day of last menstrual cycle o you currently need/use contraception? If yes what? ly periods are: ()regular. ()irregular. ()cramps. ()abnormal bleeding. ()other: Please list all current medications: or if none please check here: () Name	mail Addre	ess					_
Supplements: ()multivitamin. ()calcium. ()vitamin D. ()other: Please list any allergies: ()none. ()latex. ()peanuts. ()other: Please list any allergies: ()none. ()latex. ()peanuts. ()other: Please list any allergies: ()none. ()latex. ()peanuts. ()other: Please list any allergies: ()none. ()latex. ()peanuts. ()other: Allergy Reaction	Reason for	Appointment: () Annual routine;	OR () Ot	ther/problem: _			_
irist day of last menstrual cycle o you currently need/use contraception? If yes what?	request th	ese tests today: ()Pap Smear. ()	STD test.	()HIV test. ()	cholesterol.		
irist day of last menstrual cycle o you currently need/use contraception? If yes what?)other:						
Please list all current medications: or if none please check here: { } Name	·			If yes what?			
Name Dose Directions Reason Prescribe	ly periods a						
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Currently are you experiencing any problems in the following areas? Issue	ew person	al updates					
Currently are you experiencing any problems in the following areas? Issue	ou fomily	undatas					
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Ears, nose, throat Heart/circulation Lungs/breathing Stomach/digestion Neurologic Psychiatric Endocrine Blood/lymph					-		
Heart/circulation Psychiatric Lungs/breathing Endocrine Stomach/digestion Blood/lymph		•					
Lungs/breathingEndocrineStomach/digestionBlood/lymph							
Stomach/digestion Blood/lymph					•		
		Reproduction/urinary			Allergies		

Doctor

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

Health Questionnaire for New Patients

PAP test:Re our PAP tests been normal?								
): () none; OR LIST ALL (includ	e com	plic	ations):				<u>.</u>	
ions: () none; OR LIST ALL:								
ions. () none, on List ALL								
MEDICAL HISTORY:								
Have you ever been diagnosed with:	Yes		No				Yes	No
Cancer/type				ST	D			
Diabetes						ıre disorder		
Heart or lung disease						oid disorder		
High blood pressure						exposure?		
Stroke				Ski	in į	problems		
Kidney or liver disease				Blo leg		l clot in lungs o	r	
Genetic Disease						(Gardasil) nations		
Migraine headaches				Gy dis		cological der		
Infertility treatment/medication				Blo	oc	transfusion		
Other				Ort	ho	pedic problem	s	
TORY								
Has a family member ever been		Fan	nily Mer	nber		Alive? Com	ments:	
diagnosed with:								
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 (pleas	e incl	<u>ude</u>	all preg	nanc	cie	s):		
	ht of		Gende			nesthesia?	Complica	tions

Capital	Women's	Care
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Doctor____