CAPITAL WOMEN'S CARE

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"Working Together For Women's Health"

Print Name:_____ Date:_____

Race:____African American_____Asian_____Caucasian_____Hispanic_____Other_____

Latex Allergy: yes___no___

Past Medical History:

Gynecological History

____Abnormal Pap Smear
____Cervical Cancer
____Cervical Dysplasia
____Cervical Polyp
____Endometriosis
___Genital Herpes
____History of STD
____Irregular Menses
____Menopausal Symptoms
____Uterine Prolapse
____Vaginal Prolapse
____Other_____

Breast History

____Abnormal Mammogram
____Breast Cancer
____Breast Cysts/Mass
____Other_____

Cardiovascular History

____Cardiac Arrest
____Hypertension
____Deep Vein Thrombosis
____Heart Murmur
____Mitral Valve Prolapse
____Phlebitis
____Transient Ischemic Attack
____Other_____

Endocrine History

____Diabetes
____Hyperthyroidism
____Hypothyroidism
____Ovarian Dysfunction
____Other_____

Hematologic History

___Anemia
___Sickle Cell Carrier
___Sickle Cell Disease
___Other_____

Psychiatric History

___Anxiety
___Bipolar Disorder
___Depression
___Other_____

Past Surgical History:

Please indicate what surgical procedures you have undergone as well as the year it took place

Procedure	Location	Year

Medications:

Medication Name	Prescribed By	Dose

Allergies:

Please List all Medication Allergies

_____

_____

_____

_____

_____

Family Medical History:

Please Mark all that Apply

___Breast Cancer

___Ovarian Cancer

___Uterine Cancer

___DVT

___Diabetes

__Glaucoma

__Heart Disease

__Hypertension

__Multiple Births

__Osteopenia

Menstrual History

_____Age of Onset
_____Cycle Duration
_____Cycle Interval
_____Last Menstrual Period
_____Menopausal: What year did period stop?_____

Obstetrical History

Date	Months	Birth Weight	Gender	Type of Delivery	Complications	Location

___Breech ___Cervical Incompetence ___Ectopic ___Gestational Diabetes

___Infertility ___ Miscarriage _Preterm Labor ____Post Partum Depression

___Termination ____Other_____

Social History

___Alcohol ___Elicit Drug Use ___Tobacco

Have you ever been a victim of physical abuse?_____

Have you ever been a victim of emotional abuse?_____

Exercise Regimen

___Active (4 or more days per week)
___Moderate (1-2 Days per week)
___Minimal (1 Day per week)
___None

Religion

___Christian ___Hindu
___Jewish ___Muslim
___Jehovah Witness ___Other_____

Patient Signature:_____

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