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

Roy M. Brooks, M.D.
Asha Barrett, MD
Andrew B. Block, M.D.
Julie G. Glass, M.D
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Ronald D. Jacobs, M.D.
Gayle F. Friedman, M.D.
Lauren F. Ng, M.D
Tussing, Meredith, WHNP
Anne Seifert, CNM

ANNUAL HEALTH HISTORY UPDATE

Name: _____ Age: _____ Date: _____

Telephone Number: _____ Email: _____

Have you had any other well exam within the past year at another doctor's office? Yes No Date: _____

Primary Care Physician or Provider: _____

You are scheduled for your annual history examination today. We would like you to complete the below information to help assist us with ensuring we have the most update to date information pertaining to you and your medical care.

MEDICATIONS / ALLERGIES

Current medications with dosing

_____ _____

_____ _____

Do you have an allergy to Latex? Yes ○ No ○

Do you or have you developed any medication allergies? Yes ○ No ○

If you answered yes, please list the medication and reaction

_____ _____

MENSTRUAL HISTORY

Are you menopausal? Yes ○ No ○

If you answered yes, please skip the following questions

1ST day of your last period _____ Was it normal? Yes ○ No ○

Have your cycles been regular? Yes ○ No ○

SIGNS AND SYMPTOMS

Do you have any of the following:

Abnormal Bleeding	○ Yes	○ No	Bleeding between periods	○ Yes	○ No
Pelvic Pain or Cramping	○ Yes	○ No	Mood Swings / Fatigue	○ Yes	○ No
Are you sexually active	○ Yes	○ No	Do you have a new partner	○ Yes	○ No
Painful intercourse	○ Yes	○ No	Pain with urination	○ Yes	○ No
Urinary Frequency	○ Yes	○ No	Vaginal Discharge / Odor	○ Yes	○ No

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Name: _____ Date: _____

CONTRACEPTION METHOD

What method are you currently utilizing (please circle)

Nothing Condoms Tubal Ligation IUD (Indicate Brand & Date of Insertion) _____ Vasectomy

Ring Depo-Provera Patch Pill (Indicate Brand) _____

SOCIAL HISTORY

Do you smoke? ○ Yes ○ No
If so, how much _____

Do you drink? ○ Yes ○ No
If so, how much _____

Do you exercise? ○ Yes ○ No
If so, how much _____

ADDITIONAL TESTING

Have you ever had a Mammogram? ○ Yes ○ No
If so, when _____

Have you ever had Bone Scan? ○ Yes ○ No
If so, when _____

Have you ever had a Colonoscopy? ○ Yes ○ No
If so, when _____

Have you ever had a Cholesterol Screen? ○ Yes ○ No
If so, when _____

FAMILY HISTORY

Have there been any new medical issues among your immediate family since your last visit? ○ Yes ○ No
If so, please explain _____

OTHER

Is there anything else you wish to discuss with your provider at today's visit?

_____

_____

_____ _____

Patient's Name (Please print)
Patient Name (Please Print)

Signature
Signature

Updated 10/15/2020

CAPITAL WOMEN'S CARE

PATIENT HISTORY FORM

Name _____

Date of Birth _____

Date _____

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

Reason for your visit today: _____

Current Contraception: ❑ None ❑ Tubal Ligation ❑ IUD ❑ Mirena® ❑ Nuva Ring® ❑ Patch ❑ Natural Family Planning ❑ Depo Provera ❑ Condoms ❑ Diaphragm ❑ Vasectomy ❑ Pills - Brand: _____

If Postmenopausal, are you 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 16? ..... ❑ Yes ❑ No

Were you exposed to DES before your birth? ..... ❑ Yes ❑ No

Have you ever had an abnormal PAP smear?..... ❑ Yes ❑ No

Do you exercise regularly? ..... ❑ Yes ❑ No

Do you use seat belts? ..... ❑ Yes ❑ No

Do you smoke? ..... ❑ Yes ❑ No

How much? _____

Do you drink alcohol? ..... ❑ Yes ❑ No

How much & how often? _____

Do you use any recreational drugs? ..... ❑ Yes ❑ No

What & how often? _____

Surgeries or Hospitalizations: ❑ None

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

Pregnancies (include losses and terminations)

Year	Male/Female	Weight	Vaginal or Section	Complications

Do you have or have you ever had…

Diabetes ❑ Yes ❑ No
Asthma ❑ Yes ❑ No
Stroke ❑ Yes ❑ No
Ulcers ❑ Yes ❑ No
Heart disease ❑ Yes ❑ No
Chronic anemia ❑ Yes ❑ No
Thyroid disorder ❑ Yes ❑ No

High blood pressure ❑ Yes ❑ No
Mitral valve prolapse ❑ Yes ❑ No
Seizures/Epilepsy ❑ Yes ❑ No
Tuberculosis ❑ Yes ❑ No
Bowel trouble ❑ Yes ❑ No
Kidney stones ❑ Yes ❑ No
Bleeding disorder ❑ Yes ❑ No

Chronic lung condition ❑ Yes ❑ No
Alcohol abuse ❑ Yes ❑ No
Drug/substance abuse ❑ Yes ❑ No
Hepatitis/liver disorder/Jaundice ❑ Yes ❑ No
Blood clots in legs/lung/heart ❑ Yes ❑ No
Autoimmune diseases (lupus, etc.) ❑ Yes ❑ No
Depression, anxiety ❑ Yes ❑ No

Osteoporosis ❑ Yes ❑ No
High cholesterol ❑ Yes ❑ No
Rheumatic fever ❑ Yes ❑ No
Blood transfusion ❑ Yes ❑ No
Transfusion reactions ❑ Yes ❑ No
Anesthetic reactions ❑ Yes ❑ No
Eating disorder ❑ Yes ❑ No

Cancer ❑ Yes ❑ No If yes, Type, Date and Treatment: _____

Other disease? _____

Please list any major illnesses that have occurred in your family. Is there a family history of…

Breast Cancer ❑ Yes ❑ No
Ovarian Cancer ❑ Yes ❑ No
Colon Cancer ❑ Yes ❑ No

Thyroid disorder ❑ Yes ❑ No
Coronary artery disease ❑ Yes ❑ No
High cholesterol ❑ Yes ❑ No

Osteoporosis ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No
Other: _____

Stroke ❑ Yes ❑ No
High blood pressure ❑ Yes ❑ No