CAPITAL WOMEN'S CARE
CHARLES ST. OB/GYN

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Patient History Form

Today's Date: ___/___/____

NAME: _____ BIRTHDATE: ___/___/_____ AGE: _____ PRONOUN: _____

OCCUPATION: _____ REFERRED BY:_____

MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐DOMESTIC PARTNER ☐WIDOWED ☐SEPERATED

PARTNER'S NAME: _____ PRONOUN: _____ OCCUPATION: _____

REASON FOR YOUR VISIT TODAY: _____

MAY WE SPEAK WITH YOUR PARTNER ABOUT MEDICAL CONCERNS? ☐ YES ☐ NO

MAY WE LEAVE A MESSAGE ON YOUR CELL PHONE? ☐ YES ☐ NO

LIST ALL MEDICATION/DOSAGE YOU ARE TAKING, INCLUDING OVER THE COUNTER:

_____

_____

LIST ALL ALLERGIES AND REACTIONS:_____

WHEN WAS YOUR LAST MAMMOGRAM: ___/____/____ ☐ NORMAL ☐ ABNORMAL ☐ N/A

WHEN WAS YOUR LAST PAP SMEAR: ___/____/____ ☐ NORMAL ☐ ABNORMAL ☐ N/A

IF ABNORMAL, HAVE YOU HAD ANY OF THE FOLLOWING: ☐ COLPOSCOPY ☐ LASER
☐ CONE BIOPSY ☐ LEEP

HAVE YOU HAD ANY STDs? ☐ CHLAMYDIA ☐ GONORRHEA ☐ TRICHOMONIASIS ☐ SYPHILIS
☐ HERPES ☐ GENITAL WARTS ☐ NONE

DID YOU RECIEVE YOUR HPV VACCINE SERIES (GARDASIL)? ☐ YES ☐ NO ☐ UNSURE

DO YOU EXERCISE REGULARLY?_____ DO YOU USE SEAT BELTS?_____

DO YOU SMOKE?_____ IF SO, HOW MUCH AND FOR HOW LONG?_____

DO YOU DRINK ALCOHOL?_____ IF SO, WHAT AND HOW OFTEN? _____

DO YOU USE RECREATIONAL DRUGS?_____ IF SO, WHAT AND HOW OFTEN?_____

DO YOU HAVE A HISTORY OF EMOTIONAL OR PHYSICAL ABUSE, OR DO YOU FEEL THREATENED IN YOUR CURRENT RELEATIONSHIP?_____

WHAT AGE DID YOU GET YOUR FIRST PERIOD?_____ DATE OF LAST PERIOD: _____

MENSTRUAL CYCLE INTERVAL: _____ DURATION: _____ FLOW: LIGHT / MEDIUM / HEAVY

PREGNANCY PREVENTION METHOD:_____

OBSTETRICAL HISTORY:

TOTAL # OF PREGNANCIES: __ # LIVING: __ # TERMINATED: ___ # MISCARRIAGE: ___ # ECTOPIC: ___

DATE	TYPE OF DELIVERY	EXACT GESTATION AT DELIVERY	NATURAL/ EPIDURAL/ GENERAL	# OF HOURS IN LABOR	MALE/FEMALE	WEIGHT	COMPLICATIONS

SURGICAL HISTORY:

DATE	TYPE OF SURGERY	DOCTOR	HOSPITAL/FACILITY

MEDICAL HISTORY: CIRCLE IF YOU HAVE HAD OR ARE CURRENTLY HAVING A PROBLEM WITH ANY OF THE FOLLOWING:

DIABETES	HIGH CHOLESTEROL	BLOOD CLOTS
ASTHMA	BLOOD TRANSFUSION	HIGH BLOOD PRESSURE
STROKE	TRANSFUSION REACTION	ALCOHOL ABUSE
HEART DISEASE	ANESTHETIC REACTION	ANXIETY
THYROID DISORDER	KIDNEY STONES	DEPRESSION
OSTEOPOROSIS	BLEEDING DISORDERS	SEIZURES/EPILEPSY
PSYCHIATRIC ILLNESS: _____	EATING DISORDER/TYPE: _____	CANCER/TYPE: _____

OTHER:_____

FAMILY HISTORY: CHECK ANY OF THE FOLLOWING THAT APPLY AND NOTE WHICH RELATIVE HAS DIAGNOSIS (EXAMPLE: PATERNAL GRANDMOTHER, MATERNAL AUNT, ETC.)

DIAGNOSIS	RELATIVE	DIAGNOSIS	RELATIVE	DIAGNOSIS	RELATIVE
☐ BREAST CANCER		☐ THYROID DISORDER		☐ STROKE	
☐ OVARIAN CANCER		☐ HIGH CHOLESTEROL		☐ DIABETES	
☐ COLON CANCER		☐ HEART DISEASE		☐ OSTEOPOROSIS	
☐ REFLUX OR ULCER		☐ HYPERTENSION		☐ OTHER	