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

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Please complete this NEW GYN PATIENT INFORMATION form prior to your visit.

DATE _____ NAME _____
Last First Middle Initial

DOB _____ AGE _____ EMAIL _____

PATIENT'S OCCUPATION _____

PRIMARY CARE PHYSICIAN _____

REFERRING PHYSICIAN _____

GYN HISTORY **REASON FOR VISIT:** _____

Birth Control:

- What are you currently using for contraception? _____How Long? _____

Periods:	**Breast (currently):**
• Date of last menstrual period _____ • How often do you get your period (Every how many days)? _____ • Periods lasts _____number of days • Please list any issues with cycle: --- ---	Left or Right Breast (please circle one) • Discharge: No ___ Yes ___ • Lump/s: No ___ Yes ___ • Pain: No ___ Yes ___ • Self-Exam: No ___ Yes ___

FOR WOMEN WHO ARE MENOPAUSAL

Age at menopause _____	Hot Flashes No ___ Yes ___ Insomnia No ___ Yes ___ Night Sweats No ___ Yes ___ Vaginal Dryness No ___ Yes ___	Calcium supplements? No ___ Yes ___ Vitamin D Supplements? No ___ Yes ___
Hormone Replacement Therapy? No ___ Yes ___	HRT medications:	Years taken:

HISTORY / ADDITIONAL SYMPTOMS

Abnormal Bleeding	No___ Yes___	Last Pap: _____
Abnormal Pap	No___ Yes___	Last Mammogram: _____
Abnormal Mammogram	No___ Yes___	Last Dexa Scan (If Applicable): _____
Abnormal Vaginal Discharge	No___ Yes___	Last Colonoscopy (If Applicable): _____
Anxiety / Depression	No___ Yes___	
Ovarian Cysts	No___ Yes___	
Painful Intercourse	No___ Yes___	
Sexual Concerns	No___ Yes___	
Sexually Transmitted Infections(if yes please specify) _____		
Urinary Symptoms	No___ Yes___	
Uterine Fibroids	No___ Yes___	
Vaginal Itching	No___ Yes___	

TURN OVER

MEDICAL HISTORY: Do you currently have or have you been diagnosed with:

BLEEDING / CLOTTING DISORDER	No ( ) Yes ( )
HEART DISEASE	No ( ) Yes ( )
HYPERTENSION	No ( ) Yes ( )
DIABETES	No ( ) Yes ( )
THYROID DISEASE / DISORDER	No ( ) Yes ( )
LUNG DISEASE (ASTHMA, PNEUMONIA, TB	No ( ) Yes ( )
NEUROLOGICAL DISEASE / DISORDER (STROKE, SEIZURES, MIGRAINES)	No ( ) Yes ( )
KIDNEY OR URINARY TRACT	No ( ) Yes ( )
GASTROINTESTINAL / LIVER DISEASE	No ( ) Yes ( )
DEPRESSION / PSYCHIATRIC (INCLUDING POSTPARTUM)	No ( ) Yes ( )
OTHER	No ( ) Yes ( )

MEDICATIONS ( ) NO MEDICATIONS (please include over the counter meds and supplements)

NAME (BRAND OR GENERIC)	DOSAGE	HOW OFTEN	REASON FOR MEDICATION

ALLERGIES ( ) No Known Allergies

MEDICATION ALLERGY	REACTION
Latex Allergy NO ( ) YES ( )	

PHARMACY

NAME:	ADDRESS:

OB / PREGNANCY HISTORY ( ) No Past Pregnancies

DATE	VAGINAL OR C-SECTION	BABY SEX	WEIGHT OF BABY	ECTOPIC	MISCARRIAGE	TERMINATION	COMPLICATIONS

PAST SURGICAL / PROCEDURE HISTORY ( ) No Surgical History

SURGERY / PROCEDURE	DIAGNOSIS	YEAR	SURGEON	COMPLICATIONS

TURN OVER

Have you ever experienced complications from Anesthesia: NO ( ) Yes ( )

Please Explain: _____

FAMILY HISTORY (please check the appropriate columns)

	Mother	Father	Sister	Brother	Other	Age onset/death	Comments
DECEASED							
BLEEDIBNG / CLOTTING DISORDER							
CORONARY ARTERY DISEASE/ HEART ATTACK							
STROKE							
HYPERTENSION							
DIABETES							
OSTEOPOROSIS							
THYROID DISEASE							
BREAST CANCER							
UTERINE CANCER							
OVARIAN CANCER							
COLON CANCER							
OTHER							

NUTRITION: Calcium Supplement No___ Yes___ Vitamin D No___ Yes___ MULTI VITAMIN No___ Yes___

SOCIAL HISTORY: SINGLE___ DIVORCED___ ENGAGED___ MARRIED___ WIDOW___

- Are you currently sexually active? No___ Yes___ With a: Man___ Woman___ Both___
- What is your current gender identity? (Check all that apply)
  - Female
  - Male
  - Transgender Male/Transman/FTM
  - Transgender Female/Transwoman/MTF
  - Additional Category (Please specify): _____
  - Decline to answer
- What pronouns do you prefer that we use when talking to you?
  - Please specify: _____

EXERCISE: TYPE _____ **FREQUENCY:** _____

ALCOHOL USE: _____ **FREQUENCY:** _____

TOBACCO USE: CURRENT: No___ Yes___ FORMER: No___ Yes___

CAFFEINE USE: CURRENT: No___ Yes___ TYPE _____ AMT DAILY_____

RECREATIONAL DRUGS: CURRENT: No___ Yes___ FORMER: No___ Yes___ TYPE: _____

TURN OVER

Do you want Sexually Transmitted Diseases testing (STDs)?	**No ( ) Yes ( )**
I request testing for: (please check) Gonorrhea & Chlamydia ____	*Chlamydia and Gonorrhea* are two of the most commonly transmitted STDs in the US. • *Symptoms* can include: Discharge, irregular bleeding, abnormal or pelvic pain, painful intercourse, vague bladder symptoms or they may be "silent" with no symptoms at all. • *Testing:* a sample is taken from the cervix, similar to a PAP smear. • *Cost:* ranges from $75- $125, depending on the lab your insurance requires us to use, and **MAY or MAY NOT** be covered by the insurance
I request testing for: (please check) Syphilis | Hepatitis | HIV ____	• *Syphilis, Hepatitis B / C and HIV (Aids Virus)* can be tested with a blood sample. • Your insurance **MAY or MAY NOT** cover the test.
Please sign here to authorize this testing:	***DATE:***

PATIENT SIGNATURE_____ **DATE**_____

PROVIDERS SIGNATURE_____ **DATE**_____

Thank you for taking the time to share this valuable information regarding your health.

TURN OVER