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

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OBSTETRICS AND GYNECOLOGY

Welcome to our practice! Please take a moment to fully complete this form to the best of your ability. This will begin to provide us with the necessary information to help us better understand your health care needs.

Date_____ Name_____ Age_____

Date of Birth _____ First day of Last Menstrual Period _____

If postmenopausal, age at last period _____

Are you sexually active: _____ With men, women, or both? _____

Preferred pronouns: _____

What do you use for contraception (if applicable)? _____

Primary Care physician _____

Preferred pharmacy _____

I. Reason for today's visit _____

II. Past Medical History (Include dates, diagnoses, treatment)

a. Any prior surgeries? _____

b. List any Hospitalization you have had _____

c. List all Medical Problems _____

d. List all Medications you are currently taking and dosages_____

e. List all Medications to which you are Allergic _____

f. Have you ever had any Blood Transfusions _____

g. Genetic test results (if applicable) _____

III. Social History

a. Marital Status _____

b. What kind of work do you do? _____

c. Do you smoke tobacco/marijuana/vape? _____

d. Do you drink alcohol? _____ If yes, how many drinks per week? _____

e. Do you use any recreational/illicit substances? If so, what kind/how often? _____

V. Family History (Health of Mother, Father, Siblings)
In your family, is there a history of the following (Please include age at diagnosis):

a. Breast Cancer _____ e. High Blood Pressure/ Heart Disease