Capital Women's Care
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Leesburg, VA
www.cwcashburn.com (Please visit our website!)
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Today's date:

Name: **Date of Birth:** **Occupation:**

Referred by:
Preferred pharmacy:
Main reason for your visit today:

Medical history: Please circle only what applies to YOU

High blood pressure	Yes	No	Seizures	Yes	No	Heart disease	Yes	No
Diabetes	Yes	No	Thyroid disease	Yes	No	Kidney disease	Yes	No
Asthma	Yes	No	Fibroids	Yes	No	Migraine headaches	Yes	No
Blood clots in legs or lungs	Yes	No	Stroke	Yes	No	Cancer	Yes	No
Anxiety or Depression	Yes	No	Bleeding disorders	Yes	No	Genital Herpes	Yes	No
Other (please specify):								

Gynecologic history

Last menstrual period (first day)	Date:	
Age at onset of periods	Age:	
How often do you get your period	Number of days:	
Length of your period (# of days of bleeding)	Number of days:	
Number of pads on your heaviest day	Number:	
When was your last pap smear?	Date:	
PLEASE CIRCLE YES OR NO		
Any abnormal pap smear in the past	NO	If YES, what year/type?
Have you had a sexually transmitted disease	NO	If YES, what year/type?
Any recent changes to your periods	NO	If YES, please specify:
Any bleeding between periods	NO	If YES, please specify:
Any bleeding after intercourse	NO	YES
Do you have painful periods?	NO	YES
Do you have continuous pelvic pain?	NO	YES
Do you have fibroids?	NO	YES
Do you have endometriosis?	NO	YES

Previous pregnancies? If yes, please fill the following. If none, please skip

	Year	Term (circle)?	Baby's weight	Sex	Delivery Type (circle)	Complications?
#		Yes No		M F	Vaginal C-section	
#		Yes No		M F	Vaginal C-section	
#		Yes No		M F	Vaginal C-section	

Any miscarriages or abortions in the past? If yes, fill the following. If none, please skip

	Year	Trimester (please circle)	Management type (please circle)	Complications?
#		1st 2nd 3rd	Medical D&C Expectant	
#		1st 2nd 3rd	Medical D&C Expectant	
#		1st 2nd 3rd	Medical D&C Expectant	

Any surgeries in the past? If yes, fill the following. If none, please skip

Year		Surgery	
Year		Surgery	
Year		Surgery	

Do you take any medications? If yes, fill the following. If none, please skip

Medication		Dose	
Medication		Dose	
Medication		Dose	

Do you have any allergies? If yes, fill the following. If none, please skip

Allergy to		Reaction	
Allergy to		Reaction	

Any FAMILY history of chronic medical illnesses? If yes, fill the following. If none, please skip

Diabetes	Yes	No	Relationship to you:
High Cholesterol	Yes	No	Relationship to you:
Hypertension	Yes	No	Relationship to you:
Blood clots in legs or lungs	Yes	No	Relationship to you:
Stroke	Yes	No	Relationship to you:
Cancer	Yes	No	Type and relationship to you:
Cancer	Yes	No	Type and relationship to you:
Cancer	Yes	No	Type and relationship to you:
Other (please specify):			

Please circle one (If past or current please specify)

Tobacco use: Never Past Current Specify:
Caffeine use: Never Past Current Specify:
Alcohol use: Never Past Current Specify:
Illicit drug use: Never Past Current Specify: