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:**

Preferred pharmacy:

- First day of last menstrual cycle:
- How confident are you of this date of last period? High Low
- Are your periods typically regular and predictable? Yes No

Are you having any of those symptoms currently?

Anorexia	Yes	No	leg swelling	Yes	No	Heartburn	Yes	No	Spotting	Yes	No
Bleeding	Yes	No	Fatigue	Yes	No	Anxiousness	Yes	No	Difficulty urinating	Yes	No
Breast tenderness	Yes	No	Fevers	Yes	No	Nausea	Yes	No	Vaginal discharge	Yes	No
Constipation	Yes	No	Headache	Yes	No	Pelvic pain	Yes	No	Vomiting	Yes	No
Other (please specify):											

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):								

What surgeries have you had in the past?

Year		Surgery	
Year		Surgery	
Year		Surgery	
Year		Surgery	

Do you take any medications other than your prenatal vitamins and supplements

Medication		Dose	
Medication		Dose	
Medication		Dose	

Medication		Dose	

Do you have any allergies?

Allergy to		Reaction	
Allergy to		Reaction	
Allergy to		Reaction	
Allergy to		Reaction	

Do you have any family history of chronic medical illnesses or birth defects?

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:
Birth defects	Yes	No	Type and relationship to you:
Intellectual disability	Yes	No	Type and relationship to you:
Other (please specify):			

Previous pregnancies? If yes, please fill the following

	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	
#		Yes No		M F	Vaginal C-section	

Have you experienced miscarriages or had abortions in the past? If yes, please fill the following

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

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