CAPITAL WOMEN'S CARE DIVISION 38

GYN PATIENT INFORMATION SHEET

Date _____ Patient Name _____

DOB _____ Last Menstrual period: _____
Marital status: M_____ S _____Other _____
Primary Care Physician _____Height _____ Weight _____
Present Birth Control: _____ Past Birth Control Methods: _____

MEDICATIONS [ ] No Medications

Brand/Generic Name	Prescribing Physician	Start Date	Dosage/How Often

Additional medications - Attach list

ALLERGIES [ ] No Known Allergies

Allergy	Reaction

PREGNANCY HISTORY

YEAR	BIRTH WEIGHT	SEX OF CHILD	COMPLICATIONS

Number of pregnancies	
Number of full term pregnancies	
Number of preterm deliveries	
Number of miscarriages / abortions	
Number of live births	
Number of vaginal deliveries	
Number of caesarean deliveries (C-sections)	
Number of living children	

PAST MEDICAL HISTORY [ ] No Known Past Medical History

Disease	Year Diagnosed	Treatment	Resolved	Yes	No

PAST SURGICAL HISTORY [ ] No Surgical History

Name of Procedure	Diagnosis	Year Diagnosed	Date of Procedure

FAMILY HISTORY (Please check appropriate columns)

Diagnosis	Father	Mother	Sister	Brother	Other Relative(s)
Alive and Well					
Alcoholism					
Asthma					
Autoimmune Disorder					
Breast Cancer					
Cervical Cancer					
Blood clotting problems					
Colon Cancer					
Congenital Heart Defect					
Heart attack					
Stroke					
Cystic Fibrosis					
Depression					
Developmental Delay					
Diabetes					
Down Syndrome					
Hemophilia-A					
High cholesterol					
High blood pressure					
Mental Illness					
Mental Retardation					
Muscular Dystrophy					
Ovarian Cancer					
Seizure Disorder					
Sickle Cell Disease					
Spina Bifida					
Thyroid Disease					
(Other)					

SOCIAL HISTORY

Tobacco Use: Yes [ ] No [ ] Former Use [ ] Type_____

Alcohol Use: Yes [ ] No [ ] Former Use [ ] Type _____

Caffeine Use: Yes [ ] No [ ] Type _____ Amt. Daily _____

History of Domestic Violence Yes [ ] No [ ]

PHARMACY

Name	***Phone Number***

HEALTH MAINTENANCE HISTORY

Test	***Date***	***Normal***	***Abnormal***
Last pap smear			
Last Mammogram			
Last DEXA scan			
Last Colonoscopy			

MENSTRUAL HISTORY

Age of Onset		
Regular?	Yes	No
Date of Last Period		
Perform Self Breast Exams?	Yes	No

PRESENTLY HAVE?	**YES**		**YES**
Chest pain		Pain on urination	
Leg swelling		Blood in urine	
Irregular heartbeat/palpitations		Incontinence	
Chills, fever		Vaginal discharge/itching	
Heat/Cold intolerance		Easy bruising/bleeding problems	
Weight gain/loss		Change in mole color	
Increased thirst		Rashes/hives/dermatitis	
Ear infection/sore throat		Back/joint/muscle pain	
Visual changes		Headache(Migraines, tension, vascular)	
Constipation		Anxiety/Depression	
Change in appetite		Chronic cough/asthma/pulmonary problems	
Nausea/vomiting/diarrhea		Shortness of breath	