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

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New Gynecological Appointment Patient Questionnaire

Name _____ Date _____

DOB _____ Primary Care Physician _____

Pharmacy Name _____ First Day of Last Menstrual Period _____

Pharmacy Address _____ Method of Birth Control _____

Reason for Visit:

☐ Routine exam (Annual exam / Well Woman Exam)

☐ Problem visit _____

_____

Previous Pregnancies: (number of)

☐ None

Full term _____ Premature _____ Living Children _____

Vaginal Deliveries _____ C-sections _____ Abortions / Miscarriages _____

Gynecological History:

Last PAP smear _____ Last Mammogram _____

Last colonoscopy _____ Last DEXA scan _____

Have you received the HPV vaccine? Y N

Menses occurs every _____ days Menstrual cycle lasts _____ days

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office use only

Provider Notes

BP _____ weight _____ BMI _____

PAP CBC HCG TFT Prolactin UA C&S

cult x5 STD cult STD labs T&S

PCO Anov panel MP panel progesterone

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Medical History: Have you ever been diagnosed with ☐ **None**

1.	Diabetes	Y	N	15.	Hepatitis / Liver Disease	Y	N
2.	High Blood Pressure	Y	N	16.	Varicosities / phlebitis	Y	N
3.	Heart Disease	Y	N	17.	Thyroid Dysfunction	Y	N
4.	Autoimmune Disease	Y	N	18.	Trauma / Violence	Y	N
5.	Kidney Disorder / UTI	Y	N	19.	Blood Transfusion	Y	N
6.	Neurological Disorder / Epilepsy	Y	N	20.	History of abnormal PAP	Y	N
7.	Psychiatric Disorder	Y	N	21.	Breast problems	Y	N
8.	Depression/Postpartum Depression	Y	N	22.	HIV	Y	N
9.	Blood Clots / DVT	Y	N	23.	Uterine abnormality	Y	N
10.	D (Rh) Sensitization	Y	N	24.	Infertility	Y	N
11.	Varicella (Chicken Pox)	Y	N	25.	Fertility Treatment	Y	N
12.	Pulmonary (Asthma, TB)	Y	N	26.	Other relevant history	Y	N
13.	Seasonal Allergies	Y	N	27.	Anesthesia Complications	Y	N
14.	Medication / Latex allergies	Y	N	28.	Other	Y	N

Surgical History (please list all surgeries and procedures, including in-office procedures) ☐ **None**

Year Procedure

_____ _____

_____ _____

Medications (please list all medications including over the counter and herbal medications) ☐ **None**

Name Dosage Reason for taking

_____ _____ _____

_____ _____ _____

Allergies (please list all medication allergies) ☐ **None**

Name of medication Reaction

_____ _____

Social History

Do you use tobacco products? Y N Type_____ # per day _____

Have you ever had any STDs? Please circle ☐ **None**

HIV Gonorrhea Chlamydia Trichomonas Syphilis Herpes HPV Hepatitis B or C

Family History: (Is there any blood relative in your family diagnosed with?) ☐ **None**

Breast cancer Y N _____ Age at diagnosis _____

Ovarian cancer Y N _____ Age at diagnosis _____

Colorectal cancer Y N _____ Age at diagnosis _____