Capital Women's Care Hagerstown

Name:_____ **DOB:**_____ **Today's Date:**_____

Reason for visit:_____

Last pap smear:_____ **Last mammogram:**_____ **Last Bone Density Test (DEXA):**_____ **Last colonoscopy:**_____

Have you received your HPV vaccation series? □ No □ Yes Dates:_____

Marital status: □ Single □ Married □ Divorced □ Widowed **Sexual orentation:**_____ **Gender identity:**_____

Employer:_____ **Occupation:** _____

# of pregnancies:_____ Indicate number of each of the following:

Full term	Pre term	Miscarriages	Terminations	Ectopic	Living children	C-section	Vaginal delivery

Medical History: (Please check any of the following that apply to ***YOU).***

□ Abnormal pap
□ Anemia
□ Anesthesia complications
□ Anxiety
□ Asthma
□ Autoimmune disease
□ Bartholin's gland cyst
□ Blood transfusion
□ Breast mass
□ Brusing/bleeding disorder
□ Blood clotting disorder
□ DVT
□ Depression
□ Diabetes
□ Endometriosis
□ Fibroids in uterus
□ Gastric reflus
□ Headaches/migraines
□ Heart attack
□ Hepatitis/liver disease
□ High cholesterol
□ High blood pressure
□ IBS
□ Ovarian cyst
□ Polycystic ovaries
□ Pulmonary embolism
□ Seizure disorder
□ Thyroid disease
□ UTI, recurrent
□ STD/PID:
  □ Gonorrhea
  □ Chlamydia
  □ Genital herpes
  □ HIV
  □ Syphilis
  □ HPV
□ Cancer:
  □ Cervical cancer
  □ Ovarian cancer
  □ Breast cancer
  □ Uterine cancer
  □ Other:_____

Surgical History: (Include elective procedures. Attach additional paper if needed).

□ Hysterectomy
□ Tubal ligation
□ C-section (Number:_____)
□ _____
□ _____
□ _____
□ _____
□ _____

Family History: (Please list family members who have the following conditions, & approximate age of diagnosis, if known. If any family member has a condition not listed, please add this to "Other").

□ Breast cancer:_____
□ Cervical cancer:_____
□ Ovarian cancer:_____
□ Uterine cancer:_____
□ Colon cancer:_____
□ Autoimmune disoder:_____
□ Coagulopathy (blood clots):_____
□ Osteoporosis:_____
□ Thyroid disease:_____
□ Heart attack/heart disease:_____
□ Stroke:_____
□ Diabetes:_____
□ High cholesterol:_____
□ High blood pressure:_____
□ Mental illness:_____
□ Other:_____

Social History:

Tobacco use:
□ Never
□ Former
□ Current
Details:_____

Alcohol use:
□ Never
□ Former
□ Current
Details:_____

Drug use:
□ Never
□ Former
□ Current
Details:_____

Provider Signature:_____ **Date:**_____