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

Roy M. Brooks, M.D.
Asha Barrett, MD
Andrew B. Block, M.D.
Julie G. Glass, M.D
Eric Ashkin, MD.
Ronald D. Jacobs, M.D.
Gayle F. Friedman, M.D.
Lauren F. Ng, M.D
Tussing, Meredith, WHNP
Anne Seifert, CNM

ANNUAL HEALTH HISTORY UPDATE

Name: _____ Age: _____ Date: _____

Telephone Number: _____ Email: _____

Have you had any other well exam within the past year at another doctor's office? Yes No Date: _____

Primary Care Physician or Provider: _____

You are scheduled for your annual history examination today. We would like you to complete the below information to help assist us with ensuring we have the most update to date information pertaining to you and your medical care.

MEDICATIONS / ALLERGIES

Current medications with dosing

_____ _____

_____ _____

Do you have an allergy to Latex? Yes ○ No ○

Do you or have you developed any medication allergies? Yes ○ No ○

If you answered yes, please list the medication and reaction

_____ _____

MENSTRUAL HISTORY

Are you menopausal? Yes ○ No ○

If you answered yes, please skip the following questions

1ST day of your last period _____ Was it normal? Yes ○ No ○

Have your cycles been regular? Yes ○ No ○

SIGNS AND SYMPTOMS

Do you have any of the following:

Abnormal Bleeding	○ Yes	○ No	Bleeding between periods	○ Yes	○ No
Pelvic Pain or Cramping	○ Yes	○ No	Mood Swings / Fatigue	○ Yes	○ No
Are you sexually active	○ Yes	○ No	Do you have a new partner	○ Yes	○ No
Painful intercourse	○ Yes	○ No	Pain with urination	○ Yes	○ No
Urinary Frequency	○ Yes	○ No	Vaginal Discharge / Odor	○ Yes	○ No

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Name: _____ Date: _____

CONTRACEPTION METHOD

What method are you currently utilizing (please circle)

Nothing Condoms Tubal Ligation IUD (Indicate Brand & Date of Insertion) _____ Vasectomy

Ring Depo-Provera Patch Pill (Indicate Brand) _____

SOCIAL HISTORY

Do you smoke? ○ Yes ○ No
If so, how much _____

Do you drink? ○ Yes ○ No
If so, how much _____

Do you exercise? ○ Yes ○ No
If so, how much _____

ADDITIONAL TESTING

Have you ever had a Mammogram? ○ Yes ○ No
If so, when _____

Have you ever had Bone Scan? ○ Yes ○ No
If so, when _____

Have you ever had a Colonoscopy? ○ Yes ○ No
If so, when _____

Have you ever had a Cholesterol Screen? ○ Yes ○ No
If so, when _____

FAMILY HISTORY

Have there been any new medical issues among your immediate family since your last visit? ○ Yes ○ No
If so, please explain _____

OTHER

Is there anything else you wish to discuss with your provider at today's visit?

_____

_____

_____ _____

Patient's Name (Please print)
Patient Name (Please Print)

Signature
Signature

Updated 10/15/2020