Capital Women's Care
1850 Town Center Parkway, Suite 459
Reston, Virginia 20190
www.cwcreston.com

Patient Information Questionnaire

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

Reason for visit:_____**Preferred pharmacy**: _____

Primary Care Provider:_____**Who Referred you to our practice**: _____

Latex Allergy? Yes____No____**List Allergies/Reaction**: _____

_____

Current Medications: _____

_____

First day of last menstrual cycle:_____or **Age of Menopause:**_____(Do you take hormones? Yes___No___)

Age at first menstrual cycle:_____**Cycle Duration**:_____Days **Last pap smear**: _____

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

Have you received your HPV vaccination series? No_____Yes_____Dates:_____

Current method of contraception (birth control): _____

# of Pregnancies_____: Indicate Number for Each of the Following

Full Term	Preterm	Miscarriages	Terminations	Ectopic	Living Children	C-Section	Vaginal Del

Marital Status: Single ___Married ___Divorced ___Widow___**Sexual Orientation**: _____

Highest Level of Education (Circle One): High School Some College College Grad Tech School Med School

Employer:_____**Occupation**: _____

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 Cancer
- ☐ Breast Mass
- ☐ Bronchitis
- ☐ Bruising/bleeding disorder
- ☐ Blood clotting disorder
- ☐ Cervical Cancer
- ☐ Chronic back pain
- ☐ Congenital heart defect
- ☐ Cystocele
- ☐ Depression
- ☐ DES exposure
- ☐ Diabetes
- ☐ Drug/Alcohol use
- ☐ Endometriosis
- ☐ Fibroids in uterus
- ☐ Gallbladder disease
- ☐ Genital Herpes
- ☐ Gastric Reflux
- ☐ Headaches/Migraines
- ☐ Heart Attack
- ☐ Heart murmur
- ☐ Hepatitis/Liver disease
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Infertility
- ☐ IBS
- ☐ Phlebitis
- ☐ Obesity
- ☐ Ovarian Cancer
- ☐ Ovarian Cyst
- ☐ PID
- ☐ Pneumonia
- ☐ Polycystic ovaries
- ☐ Psychiatric disease (OCD, panic attack, bipolar)
- ☐ Pulmonary embolism
- ☐ Seizure disorder
- ☐ Skin Cancer
- ☐ Skin Disorder (eczema, psoriasis)
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Uterine Cancer
- ☐ UTI, recurrent
- ☐ Vaginal infections
- ☐ STD
- ☐ Other: _____

Review of Systems: Please check any recent (within 6 months) or current issues you have

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Visual changes
- ☐ Breast concerns (pain, mass/lump, discharge)
- ☐ Unintentional weight gain or loss
- ☐ Nausea/vomiting/diarrhea/constipation
- ☐ Pain with urination
- ☐ Ringing of the ears
- ☐ Muscle weakness
- ☐ Other: _____

Surgical History: Include elective procedures & attach additional paper if needed

Date of Surgery:	Type of Surgery:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History:

Please indicate the family member by putting a check mark in the box. If the family member is someone other than those listed please indicate maternal or paternal (aunt, uncle, grandmother or grandfather).

Diagnosis:	Mother	Father	Sister	Brother	Other	Other
Alive and Well						
Deceased (indicate cause)						
Alcoholism						
Asthma						
Autoimmune disorder						
Breast Cancer						
Cervical Cancer						
Coagulopathy (Blood clots)						
Colon Cancer						
Heart attack						
CAD/Heart Disease						
Stroke						
Depression						
Diabetes						
High Cholesterol						
High Blood Pressure						
Mental Illness						
Osteoporosis						
Ovarian Cancer						
Seizure disorder						
Skin Cancer						
Thyroid disease						
Other _____						

Tobacco Use: □ Never □ Current □ Former
Type: _____
Packs per day: _____
Years Smoked: _____

Caffeine Use: □ No □ Yes
Type:_____
Amount per day: _____

Alcohol Use: □ No □ Yes □ Former
Type:_____
Amount:_____
Frequency: _____
Last Drink: _____

Provider Signature_____Date _____