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CAP WOMEN'S HEALTH

Name _____ Today's Date: _____ Date of Birth: _____

MENSTRUAL HISTORY	YES	NO
Regular periods		
Pain with period		
Bleeding between periods		
Cramps		
Mood swings/irritability		
Weight gain		
Breast tenderness		
Age at first period		

Period is: (circle) Light / Moderate / Heavy / Clots

GYNECOLOGICAL HISTORY	YES	NO
History of Abnormal Pap		
Resulting procedures performed?		

_____

UTERINE ABNORMALITIES	YES	NO
Infection of the tubes/uterus		
Uterine fibroids		
Ovarian cysts		
Endometriosis		
Cervicitis		

SEXUALLY TRANSMITTED DISEASES	YES	NO
Gonorrhea		
Syphillis		
Chlamydia		
Genital Herpes		
Genital Warts		
Trichomonas		

CONTRACEPTIVE HISTORY		
HAVE YOU USED:	YES	NO
Pill		
IUD		
Diaphragm		
Condom		
Nuva-Ring		
Tubal ligation		
Depo Provera		

Problems/Side Effects _____

_____

OBSTETRICAL HISTORY	NUMBER OF:
Total Pregnancies	
Full Term Pregnancies	
Preterm Pregnancies	
Miscarriages	
Abortions	
Living Children	

PERSONAL MEDICAL HISTORY	YES	NO	WHEN
Diabetes			
Thyroid problems			
Cancer			
Heart Disease			
Breast disease/mass			
Stroke			
Anemia			
Bladder or Kidney disease			
Depression			
Liver disease/Hepatitis			
Migraines			
Blood vessel clots			
Lung disease			

HOSPITALIZATIONS & SURGERIES

please include dates

MEDICATIONS

Allergies to medications?

Are you on any medications?

FAMILY MEDICAL HISTORY			
HAS ANYONE IN YOUR FAMILY HAD:	YES	NO	RELATIVE
High Blood Pressure			
Diabetes			
Heart Disease			
Stroke			
Alcoholism			
Osteoporosis			
Inherited genetic disease			
Cancer			
Other			

SEXUAL HISTORY	YES	NO	DETAILS
Age at first intercourse			
Are you currently sexually active			
Any pain during intercourse			
Bleeding with intercourse			
Do you practice anal sex			
Frequency of sex per week			
Have you had a new partner in the last two months?			

HABITS	YES	NO	FREQUENCY
Do you smoke cigarettes?			
Consume alcoholic beverages?			
Do you use illegal drugs?			