CAPITAL WOMEN'S CARE

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GYN RETURN PATIENT INTERIM REPORT Date: ___/___/___

Patient Name: _____ DOB: ___/___/___

First Day of Last Period: ___/___/___Preferred Pharmacy: _____

Method of Contraception: **Pills/Condoms/Patch/Ring/IUD/Tubal/Vasectomy/Abstinence/Other:**_____

PCP: _____

Would you like a chaperone during your intimate exam today? ***Yes / No***

Tobacco use: Current/ Former/ Never
Cigarette use: ____ cigarettes per day for ___ years
Other Tobacco use: _____

Alcohol use: ___ servings per day/ week/ month

Medications (including over-the-counter, supplements, and herbs):

Allergies to medications and/or Latex (please include reaction):

Changes in Medical/Surgical History:

Changes in Family History:

Do you have a family history of Breast, Ovarian, Uterine, Prostate, or Colon Cancer?_____

*If yes, who and at what age(s)?*_____

Please list the main reason for your visit today: _____

_____

Please let us know if you have any of the following symptoms: fatigue, fever, weight gain/loss, hearing loss, visual changes, short of breath, cough, chest pain, edema, abdominal pain, blood in stool, nausea/vomiting, discomfort when urinating, leaking urine, painful periods, painful intercourse, irregular periods, vaginal discharge, breast lump, skin lesion, hair changes, headaches, seizures, anxiety, depression, insomnia, cold/heat intolerance, back pain, joint pain, easy bleeding or bruising, food allergies, seasonal allergies, other:_____

Provider Signature:_____ **Date**: ___/___/___