CAPITAL WOMEN'S CARE
*Working Together for Women's Health*

**301.681.3400**

**OBGYNCWC.COM**

***Please complete this NEW OB PATIENT INFORMATION form prior to your visit.*** *Thank you*

DATE _____ NAME _____
Last First Middle Init

DOB _____ AGE _____ **LAST MENSTRUAL PERTIOD** _____

EMAIL _____ PRIMARY CARE PHYSICIAN _____

PATIENT'S OCCUPATION _____

PARTNER'S NAME _____ PARTNER"S OCCUPATION _____

**PREGNANCY HISTORY ( ) No Past Pregnancies**

| DATE | VAGINAL | C-SECTION | ANESTHESIA | WEIGHT OF BABY | LOCATION OF BIRTH | DELIVERING DOCTOR | COMPLICATIONS |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

**MISCARRIAGES, ECTOPIC PREGNANCIES OR TERMINATIONS**

| DATE | MISCARRIAGE | TERMINATION | ECTOPIC | COMPLICATIONS |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**SINCE YOUR LAST MENTSTRUAL PERIOD (PLEASE CHECK ANY THAT APPLY)**

| | | |
|---|---|---|
| Abdominal cramps _____<br>Breast tenderness _____<br>Edema (swelling) _____<br>Fever _____<br>Headaches _____<br>Nausea / vomiting _____<br>Radiation exposure _____ | Rubella exposure _____<br>Urinary complaints _____<br>Vaginal discharge _____<br>Vaginal bleeding _____<br>Viral exposure _____ | Symptoms since LMP: |

**ALLERGIES ( ) No Known Allergies** **… for MD review**

| MEDICATION ALLERGY | REACTION |
|---|---|
| | |
| | |
| **LATEX ALLERGY NO ( ) YES ( )** | **REACTION** |

***PLEASE CONTINUE…TURN*** **OVER**

**SOCIAL HISTORY** ( ) MARRIED ( ) SINGLE ( ) WIDOW ( ) DIVORCED

- Are you currently sexually active ? No ( ) Yes ( ) With a: Man ( ) Woman ( ) Both ( )
- How many sexual partners do you currently have? _____ during your lifetime? _____

**MEDICAL HISTORY: Do you currently have or have you been diagnosed with:**

| | | | |
|---|---|---|---|
| DIABETES | No ( ) Yes ( ) | TRAUMA / VIOLENCE | No ( ) Yes ( ) |
| HYPERTENSION | No ( ) Yes ( ) | BLOOD TRANSFUSIONS | No ( ) Yes ( ) |
| HEART DISEASE | No ( ) Yes ( ) | D (RH) SENSITIZED | No ( ) Yes ( ) |
| AUTOIMMUNE DISORDER | No ( ) Yes ( ) | LUNG DISEASE (ASTHMA, PNEUMONIA) | No ( ) Yes ( ) |
| KIDNEY OR URINARY TRACT | No ( ) Yes ( ) | SEASONAL ALLERGIES | No ( ) Yes ( ) |
| NEUROLOGICAL / EPILEPSY | No ( ) Yes ( ) | BREAST | No ( ) Yes ( ) |
| PSYCHIATRIC | No ( ) Yes ( ) | GYN SURGERY | No ( ) Yes ( ) |
| DEPRESSION (INCLUDING POSTPARTUM | No ( ) Yes ( ) | ABNORMAL PAP | No ( ) Yes ( ) |
| HEPATITIS / LIVER DISEASE | No ( ) Yes ( ) | UTERINE ABNORMALITIES | No ( ) Yes ( ) |
| VARICOSE VEINS / PHLEBITIS | No ( ) Yes ( ) | OVARIAN CYST / MASS | No ( ) Yes ( ) |
| THYROID DISEASE / DISORDER | No ( ) Yes ( ) | INFERTILITY | No ( ) Yes ( ) |
| GASTROINTESTINAL | No ( ) Yes ( ) | CANCER | No ( ) Yes ( ) |
| OTHER | No ( ) Yes ( ) | *Type:* *Date:* | |

| | **AMT / DAY PRE PREGNANT USE** | **AMT / DAY PREGNANT** | **# YEARS USE** |
|---|---|---|---|
| TOBACCO | | | |
| ALCOHOL | | | |
| DRUGS;ILLICIT / RECREATIONAL | | | |
| CAFFEINE | | | |

**INFECTION HISTORY**

| | |
|---|---|
| LIVE WITH SOMEONE WITH **TB OR EXPOSED TO TB** | No ( ) Yes ( ) |
| DO YOU OR YOUR PARTNER HAVE **HISTORY OF GENITAL HERPES** | No ( ) Yes ( ) |
| HAVE YOU HAD ANY OF THE FOLLOWING **INFECTIONS** | No ( ) Yes ( ) |
| *Check if yes*: *HEPATITIS* B /C _____ STI _____ HPV ____ GONORRHEA _____ HIV _____CHLAMIDYA _____ SYPHILLIS ___ | |
| **VIRAL ILLNESS OR RASH** SINCE YOUR LAST MENTRUAL PERIOD | No ( ) Yes ( ) |
| HAVE YOU HAD ANY **XRAYS** SINCE YOUR LAST MENTRUAL PERIOD | No ( ) Yes ( ) |
| DO YOU HAVE A **CAT** AS A HOUSEHOLD PET | No ( ) Yes ( ) |
| HAVE YOU TAKEN ANY **MEDICATIONS** | No ( ) Yes ( ) |
| *If yes, please list*: _____ | |

**PAST SURGICAL HISTORY ( ) No Surgical History**

| **SURGERY** | **DIAGNOSIS** | **YEAR** | **SURGEON** | **COMPLICATIONS** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

- **Have you ever experienced complications from Anesthesia No ( ) Yes ( )**

  **explain:** _____

- **In the event you would need a blood transfusion, would you accept a transfusion No ( ) Yes ( )**

***PLEASE CONTINUE ... NEXT PAGE***

NAME _____

**FAMILY HISTORY (please check the appropriate columns)**

| | Mother | Father | Sister | Brother | Other | Age onset or death | Comments |
|---|---|---|---|---|---|---|---|
| ALIVE AND WELL | | | | | | | |
| DECEASED | | | | | | | |
| BLEEDIBNG / CLOTTING DISORDER | | | | | | | |
| CORONARY ARTERY DISEASE /HEART ATTACK | | | | | | | |
| HYPERTENSION OR STROKE | | | | | | | |
| DIABETES | | | | | | | |
| OSTEOPOROSIS | | | | | | | |
| THYROID DISEASE | | | | | | | |
| BREAST CANCER | | | | | | | |
| UTERINE CANCER | | | | | | | |
| OVARIAN CANCER | | | | | | | |
| COLON CANCER | | | | | | | |
| OTHER | | | | | | | |

**OB GENETIC / RISK SCREENING**

WILL YOU BE **35 OR OLDER** AT THE TIME OF YOUR DUE DATE No ( ) Yes ( )

**HAVE YOU, FATHER OR BABY, OR ANY FAMILY MEMBERS HAD A PREGNANCY OR CHILD AFFECTED BY:**

| **Please check if it applies:** | **YOU** | **FATHER OF BABY** | **FAMILY MEMBER** |
|---|---|---|---|
| **ITALIAN, GREEK, ASIAN OR MEDITERRANEAN DESCENT** | | | |
| **If yes**, have either been screened for **Thalassemia** Results of screening: | | | |
| **JEWISH, CAJUN, FRENCH CANADIAN DESCENT** | | | |
| **If yes**, have either been screened for **Tay-Sachs** Results of screening: | | | |
| **JEWISH DESCENT** | | | |
| **If yes**, have either been screened for **Canavan disease** Results of screening | | | |
| **If yes**, have either been screened for **Familial dysautonomia** Results of screening: | | | |
| **If yes**, have either been screened for **Cystic fibrosis** Results of screening: | | | |
| **AFRICAN DESCENT** | | | |
| **If yes**, have either been screened for **sickle cell trait** Results of screening: | | | |

***PLEASE CONTINUE…TURN*** **OVER**

**HAVE YOU, FATHER OR BABY, OR ANY FAMILY MEMBERS HAD A PREGNANCY OR CHILD AFFECTED BY:**

| | YOU | FATHER OF BABY | FAMILY MEMBER |
|---|---|---|---|
| NEURAL TUBE DEFECTS<br>(SPINA BIFIDA, MENINGOMYELOCELE, ANENECEPHALY) | | | |
| CONGENITAL HEART DEFECT | | | |
| DOWN SYNDROME | | | |
| HEMOPHILIA / BLOOD DISORDER | | | |
| MUSCULAR DYSTROPHY | | | |
| CYSTIC FIBROSIS | | | |
| HUNTINGTON'S CHOREA | | | |
| AUTISM OR MENTAL DISORDER | | | |
| OTHER INHERITED OR GENETIC DISORDER | | | |
| MATERNAL INHERITED DISORDER (TYPE 1 DIABETES, PKU..) | | | |
| OTHER BIRTH DEFECTS | | | |
| RECURRENT PREGNANCY LOSS OR STILLBIRTH | | | |

**MEDICATIONS ( ) NO MEDICATIONS (be sure to include over the counter meds and supplements) … for MD review**

| NAME (BRAND OR GENERIC) | DOSAGE | HOW OFTEN | START DATE | NAME OF PRESCRIBING PHYSICIAN |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**PHARMACY**

| NAME | LOCATION / ADDRESS | PHONE NUMBER |
|---|---|---|
| | | |

*Thank you* **for taking the time to share this valuable information concerning your health.**

**Drs. Levitt, Berger-Weiss, Potts, Levenson, Artis, Groves and Allison Ladner, CNM, WHNP**

**REV 11/2016**



10801 LOCKWOOD DR, # 310 / 320 SILVER SPRING, MD 20901 301.681.3400 P 301.681.7982 F
19851 OBSERVATION DR. # 345 GERMANTOWN, MD 20876 301.681.3400 P 240.912.7216 F