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

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

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 ____ Breast tenderness ____ Edema (swelling) ____ Fever ____ Headaches ____ Nausea / vomiting ____ Radiation exposure ____	Rubella exposure ____ Urinary complaints ____ Vaginal discharge ____ Vaginal bleeding ____ 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 ( )**

FAMILY HISTORY (please check the appropriate columns)

	Mother	Father	Sister	Brother	Other	Age onset or death	Comments
ALIVE AND WELL							
DECEASED							
BLEEDING / 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

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:			

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 (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.

REV 2/2020

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