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

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CWC-OBGYN.COM

Today's Date_____

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

NAME _____ DOB _____ AGE _____

LAST MENSTRUAL PERIOD _____ DAYS BETWEEN PERIODS_____

PRIMARY CARE PHYSICIAN _____

PATIENT'S OCCUPATION _____

PARTNER'S NAME_____ AGE _____ PARTNER'S OCCUPATION_____

PREGNANCY HISTORY ( ) No Past Pregnancies

DATE	VAGINAL OR C/Section?	CHILD'S NAME	WEIGHT OF BABY	BIRTH GENDER	LOCATION OF BIRTH	DELIVERING DOCTOR	COMPLICATIONS (Hypertension, Diabetes, etc.)

MISCARRIAGES, ECTOPIC PREGNANCIES OR TERMINATIONS

DATE	MISCARRIAGE	TERMINATION	ECTOPIC	COMPLICATIONS

SINCE YOUR LAST MENSTRUAL PERIOD, HAVE YOU EXPERIENCED VIRAL ILLNESS, FEVER/ CHILLS, OR COUGH? IF YES, PLEASE EXPLAIN _____

ALLERGIES ( ) No Known Allergies

MEDICATION ALLERGY	REACTION

LATEX ALLERGY NO ( ) YES ( )

PLEASE CONTINUE…TURN **OVER**

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

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

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 ( )

PAST MEDICAL/SURGICAL HISTORY ( ) No Medical or Surgical History

CONDITION/DIAGNOSIS	**SURGERY (IF APPLICABLE)**	**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							
BLEEDING / CLOTTING DISORDER							
CORONARY ARTERY DISEASE /HEART ATTACK							
HYPERTENSION OR STROKE							
DIABETES							
OSTEOPOROSIS							
THYROID DISEASE							
BREAST CANCER							
UTERINE CANCER							
OVARIAN CANCER							
COLON CANCER							
OTHER/BIRTH DEFECTS							

OB GENETIC / RISK SCREENING

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

HAVE YOU HAD CARRIER SCREENING PERFORMED?

IF YES, RESULTS: _____

HAVE YOU HAD CANCER GENETIC TESTING?

IF YES, RESULTS: _____

DATE OF MOST RECENT PAP SMEAR_____

DATE OF MOST RECENT FLU SHOT_____

DATE OF MOST RECENT COVID BOOSTER_____

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 (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.**