CAPITAL WOMEN'S CARE®

New Patient Registration and Medical History

Date_____

Name_____ Date of Birth_____

By what name would you like to be called?_____

Referred by:_____

Occupation:_____

Please list all medications you are taking with dosages (including over the counter and herbal ones):

Please list and describe any allergies to medications that you have:

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New Patient Registration and Medical History (2)

Name_____ Date of Birth_____

Medical History: Please fill in if you have had any of the following:

- O migraine headaches
- O seizures
- O depression/mental health problems
- O high cholesterol
- O kidney/bladder infections
- O cancer - non-gyn
- O Other medical problems_____
- O hepatitis/jaundice
- O lupus
- O asthma
- O diabetes
- O ulcer/reflux
- O bleeding disorders
- O chicken pox
- O heart murmur/MVP
- O high blood pressure
- O thyroid disorder
- O blood clots in legs/lungs
- O gallbladder disease
- O eating disorders

Surgical History: Please fill in if you have had any of the following:

- O appendectomy
- O cholecystectomy (gall bladder)
- O wisdom teeth extraction
- O breast surgery/biopsy
- O tonsillectomy
- O ovarian surgery
- O D&C
- O laparoscopy
- O hysterectomy
- O myomectomy
- O Other operations_____

Family History: Please tell us who in your immediate family (mother, father, siblings) has any of the following:

- O breast cancer
- O ovarian cancer
- O uterine cancer
- O colon cancer
- O other cancers
- O diabetes
- O high blood pressure
- O heart disease
- O deep vein thrombosis (DVT)
- O birth defects
- O twins
- O cystic fibrosis/tay-sachs/ sickle cell anemia
- O osteoporosis
- O Other hereditary diseases:_____
- O Are you of Jewish, Mediterranean or African American descent?_____

Social History:

Do you smoke or vape?_____ How much a day?_____

Do you use alcohol?_____ How much a week?_____

Have you ever used any marijuana or other recreational drugs?_____

Have you ever been abused?_____

Are you under the care of any other doctors?

Is there anything you wish to discuss today?

CAPITAL WOMEN'S CARE®

New Patient Registration and Medical History (3)

Name_____ Date of Birth_____

Menstrual History:

First day of last menstrual period?_____

Are your periods regular?_____ If so, give interval?_____

At what age did your periods begin?_____ How long do your periods last?_____

Menstrual flow: O light O moderate O heavy

Cramps: O mild O moderate O severe

Do you have bleeding between periods?_____

Obstetric History:

Number of times you have been pregnant?_____

Number of births?_____

Describe any birth defects:_____

Pregnancies: (please use back of form if needed)

Date	Type of Delivery	At Term?	Baby's Weight	Sex	Complications

Gynecological History:

Date of last PAP test:_____ Normal?_____

Have you ever had an abnormal PAP?_____ Treatment?_____

Date of last mammogram?_____ Date of last colonoscopy?_____

Please fill in if you have ever had:

- O Endometriosis
- O Uterine Fibroids
- O Ectopic Pregnancy
- O Infertility
- O Treatment of Cervix (LEEP, cryo or cone biopsy)
- O Genital Warts/HPV
- O PID (Pelvic infection)
- O Chlamydia/Gonorrhea
- O Herpes
- O Hormone Therapy
- O Cancer - Breast or GYN (uterus, cervix, ovary)

Contraception, you or partner:_____