CAPITAL WOMEN'S CARE

MR#: _____

Division 22
Drs. Band, Sine, Resta, Lizardo, Shrout, Lin, Rose

Current Patient Questionnaire

Today's Date: _____ Reason for Visit: _____

Patient Name:_____ Date of Birth: _____

Religion: _____ Place of Birth: _____

Currently Pregnant: Yes No If yes, name of father: _____

Name of Pharmacy: _____ Phone: _____

Address: _____

Primary Care Provider: _____

Date of Last Menstrual Period: _____ **H PV Vaccine 1st:_____ 2nd:_____ 3rd:_____**

Current Medications/Birth Control

Drug	Dosage

Allergies

Type of Allergy	Reaction

Past Obstetrical History Full Term: ___Premature: ____Abortion: _____ Miscarriages: ___Living Children: _____

Have you had any changes to your medical history since your last visit with us? Yes_____ No _____

If yes, please explain: _____

Have you had any surgeries or hospitalizations or any new medical diagnoses since your last visit with us? Yes _____ No _____

If yes, please explain: _____

Have there been any changes in your family history since your last visit with us? Yes ____ No ____

If yes, please explain: _____

Social History

	Caffeine	**Tobacco**	**Alcohol**	**Recreational Drugs**
Current				
Type:				
Amount:				
Year Stopped:				

Do you feel safe in your current environment? Yes No

Are you experiencing and problems with urinary incontinence? Yes No

Test/Procedure	**Pap**	**Mammogram**	**Bone Density**	**Colonoscopy**
Year				
Result				

If someone referred you to our group, please let us know so that we may thank them: _____

_____ _____

Printed Patient Name Signature of Patient or guardian of minor