MRN:_____

CAPITAL WOMEN'S CARE

Division 22
Drs. Band, Sine, Resta,
Lizardo, Shrout, Lin,
Footer, Wagar, Vignali,
Lefkof NP

New Patient Questionnaire

Today's Date:_____/_____/_____ Reason for Visit: _____

Patient Name:_____ Date of Birth: _____
Last, First, MI

Patient Phone #_____

Religion:_____ Place of Birth: _____

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

**Last Menstrual Period_____/_____/_____ Email: _____

Name of Pharmacy:_____ Primary Care Provider:_____

Pharmacy Phone:_____

IUD Insertion Date:_____ IUD Brand:_____

Pharmacy Address:_____

Current Medications/Birth Control

Drug	Dosage

Allergies

Type of Allergy	Reaction

Past Obstetrical History

Full Term:_____Premature:_____Abortion:_____Miscarriages:_____Living Children:_____

No.	Date	Sex	Weight	Duration Of Labor	Type Of Delivery	Anesthesia	Complications

Continue to next page

HPV Vaccine **1st: _____** **2nd: _____** **3rd: _____**

GYN History	Year	Result	Treatment
Abnormal Pap			
Other GYN Problems			
STD History			

Other Past Medical History

Date	Problem/Disease

Past Surgical History

Date	Operation

Family History of Disease

(Include any history of breast cancer, ovarian cancer, or abnormal blood clots)

Family Member	Problem/Disease	Age at Diagnosis

Social History

Test/Procedure	Pap	Mammogram	Bone Density	Colonoscopy
Year				
Result				

	Tobacco	Alcohol	Caffeine	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

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