CMC CATHOLIC MEDICAL CENTER | Women's Wellness & Fertility Center
obstetrics • gynecology • reproductive care

This form is double sided

PATIENT DEMOGRAPHIC INFORMATION:

Patient Name: _____ Date of Birth: ____/____/_____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Email: _____ Preferred Method of Contact: Cell Home Work

Gender: Male / Female Marital Status: S M W D Occupation: _____

Employer Name: _____ Insurance Carrier: _____

Spouse/Guardian Name: _____ Occupation: _____

Family Members that live with you: _____

Pets: _____

Preferred Language: _____ Religious Preference (optional): _____

Ethnicity:

- □ Hispanic or Latino
- □ Non Hispanic or Latino
- □ Declined to Provide
- □ Unknown

Race:

- □ Asian
- □ Black/African American
- □ American Indian/Alaskan Native
- □ Native Hawaiian/Pacific Islander
- □ White
- □ Other Race
- □ Declined to Provide
- □ Unknown

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

What is the reason for your visit?:_____

MEDICAL HISTORY:

*Please mark below any of the problems or conditions that you have experienced in the **PAST.***

- □ Abnormal PAP history
- □ Alcohol or drug abuse
- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Blood disorders (ex: anemia)
- □ Cancer (type)
- □ Chronic bronchitis/COPD
- □ Colitis
- □ Crohn's disease
- □ Diabetes
- □ Gallbladder disease
- □ Breast disease
- □ Heart disease
- □ Hemorrhoids
- □ High blood pressure
- □ High Cholesterol
- □ Kidney disease
- □ Kidney stones
- □ Osteoporosis
- □ Seizures/epilepsy
- □ Skin disease/Skin cancer
- □ STD/STI
- □ Stroke
- □ Thyroid disease
- □ Ulcers
- □ Urine or fecal incontinence

Other: *please explain below*

_____

_____

CURRENT MEDICATIONS: (Including prescription, over the counter, vitamins, and supplements) Medication

	Name:	**Strength:**	**Frequency:**	**Reason:**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

For additional meds please attach sheet to this form

ALLERGIES

Please list the name of the medications/substance and the reaction you experienced: _____

_____

Do you have a living will or durable power of attorney? No Yes *If yes please bring a copy

SOCIAL HISTORY: *Please circle appropriate answer.*

Tobacco Use:

Do you **currently** smoke or use tobacco products? YES NO

Type (i.e. cigarettes, cigars, pipe, chew): _____ Quantity/day: ____

Have you **ever** smoked or used tobacco products? YES NO

Type (i.e. cigarettes, cigars, pipe, chew): _____ Years used:___

Do you **currently** use drugs? YES NO

Type (i.e. cocaine, heroin, marijuana, methamphetamines):

_____

Have you **ever** used drugs? YES NO

Type (i.e. cocaine, heroin, marijuana, methamphetamines):

_____

Do you drink alcoholic beverages? YES NO

How many servings per day? _____ per week? ____

Have you ever engaged in any activities that would put you at risk for HIV?

YES NO If yes please explain:_____

Do you exercise regularly? YES NO

Type: _____ Duration: _____Times per week: _____

Do you drink caffeine regularly? YES NO

How many cups per day?_____

Do you wear your seatbelt? YES NO

Are you in a relationship in which you've been hit/punched/slapped?
YES NO

Are you ever afraid of your partner? YES NO

PAST SURGICAL HISTORY

Please list any past surgical history as well as any hospitalizations and the reason

Procedure/Hospitalization	**Date**

FAMILY HISTORY

Please list any diseases or conditions that your blood relatives have or had and indicate the relationship to you.

Relation	Age	Medical Conditions	Cause of death (if applicable)
Mother	_____	_____	_____
Father	_____	_____	_____
Brother	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Sister	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Other (Grandparents)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

GYNECOLOGIC HISTORY

First day of your last menstrual period: _____ Are you currently menopausal?_____ Last mammogram:_____

Last PAP smear:_____ Have you ever had an abnormal PAP smear?:_____ When?:_____

Have you ever had a sexually transmitted infection?:___ When?:_____ Type(s):_____

How many sexual partners have you had?____Current method of birth control:_____

Age onset of menstrual period: _____ Frequency (number of days in cycle):_____ Are you regular?_____

Do you currently use a fertility awareness method for family planning?_____ For how many years?_____

Are you currently trying to achieve or avoid pregnancy? Avoid Achieve

Do you have a history of:

Infertility?:_____ For how long?:_____

Recurrent miscarriage?:_____ How many?:_____

PMS?:_____ Please list your symptoms:_____

Abnormal bleeding or cycles?:____ Please describe:_____

Continuous mucous?_____ Please describe:_____

What has been the previous workup for this condition?:_____

What has been the previous treatments and response to those treatments?:_____

OBSTETRIC HISTORY

How many times have you been pregnant (including miscarriages, ectopic pregnancy, abortions):_____

How many living children do you have?_____

Pregnancy	Delivery date	How many weeks were you at delivery?	Vaginal or cesarean delivery?	Sex	Weight	Was this pregnancy a miscarriage/ectopic/abortion?	If this pregnancy was a miscarriage/ectopic, what treatments were used? None/medication/D&C (surgery)
1							
2							
3							
4							
5							

6							
7							
8							
9							
10							

Please provide the names and telephone numbers to your previous primary care physicians, as well as any specialists who have provided you care.

Provider's Name	**Telephone #**	**Reason Seen:**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Pain Management:

Here at Catholic Medical Center, we recognize chronic pain is real, and at times, debilitating. We also realize that the medications that are used to treat chronic pain have a high potential for abuse and addiction. Our goal is to minimize the use of pain medication throughout our practices. Our policy is to establish a Pain Management Agreement in an effort to prevent the misunderstandings about medicines you may take for pain management. Additionally, we may refer you to a Pain Management Clinic as deemed appropriate by you and your provider.

Contraceptives Disclaimer for patients:

At Women's Wellness and Fertility Center, we are committed to upholding the Ethical and Religious Directives for Healthcare outlined by the United States Conference of Catholic Bishops. We are committed to providing holistic care in cooperation with a woman's natural cycle. Therefore, we do not provide services for artificial reproductive technologies, elective abortions, tubal ligations, contraceptives, or provide referrals for these services. Catholic Medical Center does not condone the prescribing of drugs that suppress egg production for any reason other than directly therapeutic purposes.

This information is for your physician as part of your confidential medical record. Thank you for taking the time to complete in its entirety.

Signature: _____ Date: _____