The Chronic Pelvic Pain Center of Northern Virginia

8100 Boone Blvd | Suite 710 |Tysons Corner, VA 22182 | Phone: 703.448.6070

New Patient Medical History

Please complete this form accurately and bring it with you to your first appointment. All information provided will be kept confidential and not divulged to anyone without your request or permission.

Today's Date: _______ **Appointment Date:** _______

Name: ____ **DOB:** _________________ **Age:** _______________

Address: ____

Referring provider: ________________________________ **PCP:** _______________________________________

Allergies: ____ **Height:** _______________ **Weight:** _____________

Do you smoke? ☐ Yes ☐ No **Do you drink alcohol?** ☐ Yes ☐ No **If yes, how often?** _____________

Please provide dates where applicable.

Date of last menstrual cycle: ____ **Last annual exam:** ____________

Date of last pap smear: ____ ☐ Normal ☐ Abnormal

Date of last mammogram: ____ ☐ Normal ☐ Abnormal

Date of last colonoscopy: ____ ☐ Normal ☐ Abnormal

Date of last bone density exam: _____________________________________ ☐ Normal ☐ Abnormal

Do you have or have you ever had any of the following?

☐ Anemia

☐ Asthma/lung disease

☐ Back problems

☐ Bleeding disorder

☐ Blood transfusion

☐ Bowel problems

☐ Breast disease

Cancer (list type[s] below)

____

____

____

☐ Constipation

☐ Chronic pelvic pain

☐ Deep vein thrombosis

☐ Depression

☐ **Diabetes** ☐ 1 ☐ 2

☐ Diarrhea

☐ Endometriosis

☐ Fibroids

☐ Fibromyalgia

☐ Gallbladder disease

☐ Gene mutations (MTHFR Factor V Leiden)

☐ Gestational diabetes

☐ Heart disease

☐ **Hepatitis** ☐ A ☐ B ☐ C

☐ Herpes

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☐ High blood pressure
☐ High cholesterol
☐ HIV
☐ HPV/genital warts
☐ Hyperthyroidism
☐ Hypothyroidism
☐ IBS
☐ Infertility
☐ Interstitial cystitis
☐ Liver disease
☐ Mental illness
☐ Migraines
☐ Osteopenia
☐ Osteoporosis
☐ Pelvic pain
☐ Seizures
☐ Sexual abuse/assault
☐ Sleep apnea
☐ Skin problems
☐ STI(s)
☐ Substance abuse

MENSTRUAL HISTORY

Age when period began: ______________________

No. of days in cycle: ____________ **Cramping?** ☐ Yes ☐ No

Menstrual flow: ☐ Normal ☐ Light ☐ Moderate ☐ Heavy

Method of contraception: ________________________________

Menopause? ☐ Yes ☐ No

Are you on hormone replacement therapy? ☐ Yes ☐ No

PREGNANCY HISTORY

No. of full-term births ______________

No. of pre-term births _______________

No. of vaginal deliveries _______________

No. of miscarriages ________________

No. of C-sections ________________

No. of living children ________________

CURRENT MEDICATION HISTORY

	MEDICATION	DOSAGE (MG; MCG; ML)	FREQUENCY	PRESCRIBING PHYSICIAN
1				
2				
3				
4				
5				
6				
7				
8				

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PAST SURGERIES

☐ No past surgical history

YEAR	TYPE OF SURGERY	COMPLICATIONS?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

FAMILY HISTORY

Please place a checkmark (✓) where applicable

DISEASE	NONE	MOTHER	FATHER	BROTHER	SISTER	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	AUNT	UNCLE
Ovarian cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Uterine cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cervical cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bowel cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Interstitial cystitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Chronic pelvic pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
DVT/blood clots	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

AUTHORIZATION AND RELEASE

I hereby certify that I have completed the above information to the best of my knowledge. I authorize, consent, request, and agree to actively participate in such services as routine assessments, the performance of diagnostic tests and procedures, care, and treatment as self-referred or as ordered by my physician, his/her assistant, or designees.

____ __________________________

SIGNATURE DATE

Please fax (703-448-9292) your completed form to our office prior to your appointment. If you cannot return your form prior to your appointment, you must **arrive 30 minutes early** so we can enter your information into the computer. This information needs to be entered prior to you seeing a provider.

Thank you for your attention and cooperation.

The Staff at the Chronic Pelvic Pain Center of Northern Virginia

Office of Melissa A. Delgado, M.D., FACOG