



Cape Women's Care
Dr. George Kovacevic, M.D, Ob/Gyn
3046 Del Prado Blvd., Cape Coral, FL 33904
Phone: 239-540-9111 Fax: 239-540-9192

Registration & Consent for Care

How did you hear about us? _____ Date: _____

Name: _____ What would you like us to call you? _____

Address: _____ City: _____ Zip: _____ [] OK to send mail

Date of Birth ____ / ____ / ____ Age: _____ SS#: _____

Are you currently employed? [] No [] FT [] PT [] Home school Student: [] FT [] PT

Occupation: _____ Employer: _____

Email Address: _____ [] OK to email detailed message

****Please circle which number you would prefer we use to reach you****

Home phone: _____ [] Detailed message OK [] Call back name & number only [] **Do NOT use**

Work phone: _____ [] Detailed message OK [] Call back name & number only [] **Do NOT use**

Cell phone: _____ [] Detailed message OK [] Call back name & number only [] **Do NOT use**

Marital Status: [] Married [] Single [] Partnered [] Widowed Partner/Spouse Name: _____

Spouse Date of Birth: _____ Occupation: _____ SS#: _____

Insurance Company: _____ (please give card to receptionist to copy)

Name of Insured: _____ Employer of Insured: _____

ID#: _____ Group #: _____

Phone Number Insurance Co: _____ Address: _____

Secondary Insurance: _____ ID#: _____ Group: _____

Phone Number Insurance Co: _____ Address: _____

Whom may we contact in case of emergency?

Name: _____ Phone: _____

If you are pregnant: Number of pregnancies (including this one): _____ Number of children: _____

1st day of last menstrual period: _____ Due date: _____

Consent for Treatment and Examination

_____ (Initial) I hereby consent to examination and/or treatment by Dr. George Kovacevic at Cape Women's Care.

Responsibility for Payment and Assignment of Benefits

_____ (Initial) I assume full financial responsibility for all charges related to health services through Cape Women's Care and George Kovacevic OB/GYN, Inc or Cape Women's Care of any insurance or other benefits due to me by reason of the health services provided. A copy of this can be considered as an original for insurance purposes. **I fully understand the content of this document and all information is accurate to the best of my knowledge.**

Signature: _____ [] Patient [] Parent/Guardian Date: _____



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Your Medical History (all information on this form will be kept strictly confidential)

What is the reason for your visit today? _____

Name: _____ Date: _____

Height: _____ Usual Weight: _____ Race: _____ My health is generally good [] Yes [] No

I am currently under care for the following disease or condition: _____

What (if any) medications (prescriptions or over the counter) and/or supplements are you currently taking?

Name: _____ Dose: _____ Name: _____ Dose: _____

Name: _____ Dose: _____ Name: _____ Dose: _____

Primary Care Practitioner: _____ Others (ie Chiropractor): _____

Have you ever had surgery or been admitted to the hospital? [] Yes [] No

Year: _____ Reason: _____

Year: _____ Reason: _____

Do you have any allergies to medicines or substances (ie Latex)? [] Yes [] No If Yes, please list below.

Do you smoke? [] No If so, how much? _____ If you quit, how long ago? _____

How many alcohol drinks per week? [] None _____ Caffeinated drinks per day? _____

Regular exercise? Type/Amount per week: _____

Do you have any questions or concerns about your health you would like to discuss today? [] No If yes, please list

Past Medical/Family History/Review of Systems [] I do not know my family medical history

Please indicate who had the problem: M – mother; F – father; S – sister; B – brother; MA – mother's sister; PA – father's sister; MU – mother's brother; PU – father's brother; MGM or MGF – mother's parents; PGM or PGF – father's parents

Please check the box if YOU or Anyone in your family has had any of the following:

Disease	Yourself	Family (specify who)
Alzheimer's – Senile Dementia		
Anemia		
Anxiety – Depression		
Arthritis – Joint Pain/Problems – Orthopedic surgery		
Asthma – Allergies – Sinus Problems		
Blood Clotting Disorder – Sickle Cell Anemia – Blood Transfusion		
Birth Defect – Congenital Disease (i.e. Downs Syndrome, Cleft Lip/Palate, Cystic Fibrosis, Heart defect, Muscular Dystrophy, Spina Bifida)		
Breast Problems – Breast surgery (not cancer)		
CANCER (Please note type, age at diagnosis, if known) Most Important: Breast, Cervical, Uterine, Lung, Colon		
Diabetes – Diabetes of Pregnancy		
Digestive Problems (Ulcer, GERD, Heartburn, Bowel Disease)		
Eating Disorder – Anorexia – Bulimia		
Epilepsy – Seizures		
Gallbladder – Liver Disease/Surgery		
Headache – Migraines (note medications used)		
Heart Disease – Heart attack – Heart Surgery – Heart Murmur		
High Blood Pressure		
High Cholesterol		
Kidney Disease – Urinary Tract Infections		
Osteoporosis		
Thyroid Dysfunction		
Stroke		
Sleep problems – Sleep Disorder		
Varicose Veins – Thrombophlebitis (blood clots in veins)		



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Immunizations

Illness	Vaccinated	Had Disease	Don't Know/Not Sure
Measles			
Mumps			
German Measles			
Chicken Pox			
Polio			
Rheumatic Fever			
Tetanus			
Hepatitis			

Gynecological/Family Planning/Contraceptive History

Age at First Period: _____ 1st day of last menstrual period: _____
How often do you get your period: _____ How many days do your periods last: _____
Do you have cramps? [] Yes (describe) _____ [] No My periods are [] Light [] Medium [] Heavy
Do you have PMS symptoms before your period [] Bloating [] Breast tenderness [] Mood swings [] Headaches
If so, what have you tried to relieve the symptoms and what has worked? _____

Menopause Questions: Symptoms now or in the past? [] Hot flashes [] Vaginal dryness [] Mood swings
[] Memory changes [] Skin changes [] Changes in your sex life/desire [] Headaches
[] Other
[] Currently using Hormone Replacement: Type: _____
Are you now taking, or have you taken anything in the past for these menopause symptoms? [] Yes [] No

Do you feel you are at risk for Sexually Transmitted Diseases? [] Y [] N Explain: _____
Have you ever been in an abusive relationship or been abused: [] Y [] N Are you currently experiencing abuse? [] Y [] N
Have you ever had a Mammogram? [] Y [] N Date of last Mammo: _____ Any abnormal Mammo: [] Y [] N
When was your last Pap smear? _____ Do you have Paps done regularly (approx. once a year) [] Y [] N
Have you ever had an abnormal Pap smear result? [] Y [] N If so, explain: _____
Have you ever had (please note year/age) [] None [] Chlamydia _____ [] Gonorrhea _____ [] PID _____
[] Herpes (oral/genital) _____ [] Genital Warts _____ [] HPV _____ [] Syphilis _____
Do you have frequent yeast infections: [] Y [] N If so, how often? _____
Have you ever had Bacterial Vaginosis (B.V.)? [] Y [] N Last time treated _____
Do you ever leak or lose urine, i.e. when you cough or sneeze? _____
Have you ever had a problem with your ovaries (i.e. ovarian cyst)? [] Y [] N Surgery on tubes or ovaries? [] Y [] N
Have you ever had a problem with your uterus (i.e. fibroids, endometriosis)? [] Y [] N Treatment/Surgery: _____
What are you currently using for birth control? _____ Are you satisfied with your current method [] Y [] N
What have you used in the past, and what (if any) problems did you have? _____

Pregnancy History

Have you ever been pregnant? [] Y [] N Are you currently seeking pregnancy? [] Y [] N [] Later _____
In past pregnancies, did you have any of the following problems? [] High blood pressure [] Diabetes [] Anemia
[] Pre-term labor/delivery [] Twins/multiples [] Cesarean delivery [] Other _____