

Date _____

Nikolas G. Capetanakis, D.O.

535 Encinitas Boulevard, Suite 120

Encinitas, California 92024

(760) 634-2814 · fax (760) 634-6785

www.DrCap.net

Name _____
Last First Middle

Final Due Date _____ LMP _____ Drug Allergies _____

Birth Date	Age	Race	Marital Status S M W D SEP	Address	Phone Number
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Father of Baby & Phone Number	Emergency Contact & Phone Number	Patient's Occupation & Type of Work EDUCATION (Last Grade Completed):
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OBSTETRICAL HISTORY						
Total Pregnancies	Full Term	Premature	Induced Abortion	Spontaneous Abortion	Multiple Births	Living Children

PAST SIX PREGNANCIES									
Delivery Date	Gest. Weeks	Birth Weight	Sex M/F	Type of Delivery	Anesthesia Yes/No	Comments/Complications	Length of Labor	Place of Delivery	Preterm Labor Yes/No

PAST MEDICAL HISTORY			
	Yes	No	Detail Positive Remarks -- Include Date & Treatment
Diabetes	_____	_____	_____
Thyroid problems	_____	_____	_____
Cancer	_____	_____	_____
Heart Disease	_____	_____	_____
Breast disease/mass	_____	_____	_____
Stroke	_____	_____	_____
Anemia	_____	_____	_____
Bladder or Kidney disease	_____	_____	_____
Depression	_____	_____	_____
Liver disease/Hepatitis	_____	_____	_____
Migraines	_____	_____	_____
Blood vessel clots	_____	_____	_____
Lung disease	_____	_____	_____
Tobacco	_____	_____	_____
Alcohol	_____	_____	_____
Illicit Drugs	_____	_____	_____
Surgeries & Hospitalizations	_____	_____	_____

