CAPITAL WOMEN'S CARE
Working Together for Women's Health

Jessica Berger- Weiss, MD
Adrienne Potts, MD
Courtney Levenson, MD
Ashley Artis, MD
Heather Brillhart, MD
Gayle Skinner, MD
Ashleigh Bouchelion, MD, PHD
Emily Fredrickson, APNR, WH-BC
Alyssa Newman, MSN, CRNP
OBGYNCWC.COM

Please complete this NEW GYN PATIENT INFORMATION form prior to your visit.

DATE _____ NAME _____
Last First Middle Init

DOB _____ AGE _____ EMAIL _____

PATIENT'S OCCUPATION _____

PRIMARY CARE PHYSICIAN _____

GYN HISTORY

Birth Control:

- What are you currently using for contraception? _____How Long? _____

Periods:	**Breast (currently):**
• Date of last menstrual period __/__/__ • How often do you get your period?_____ • Periods last _____number of days • Periods are **painful** **No ( ) Yes ( )** • Any medications used: _____ • Do the medications relieve your pain ? ____ • Excessively **heavy** **No ( ) Yes ( )** • Heavy Days (# tampons or pads) _____	side • Discharge No ( ) Yes ( ) _____ • Lump/s No ( ) Yes ( ) _____ • Pain No ( ) Yes ( ) _____ • Self-Exam No ( ) Yes ( )

FOR WOMEN WHO ARE MENOPAUSAL

Age at menopause _____	Hot Flashes No ( ) Yes ( ) Insomnia No ( ) Yes ( ) Night Sweats No ( ) Yes ( ) Vaginal Dryness No ( ) Yes ( )	Do you take Calcium supplements No ( ) Yes ( )
Hormone Replacement Therapy No ( ) Yes ( )	HRT medications:	Years taken:

ADDITIONAL SYMPTOMS

Abnormal bleeding	No ( ) Yes ( )	Waking to urinate	No ( ) Yes ( )
Anxiety	No ( ) Yes ( )	Sexual dysfunction	No ( ) Yes ( )
Decreased desire for sex	No ( ) Yes ( )	Sleep disturbances	No ( ) Yes ( )
Depression	No ( ) Yes ( )	Urinary Incontinence	No ( ) Yes ( )
Difficulty falling asleep	No ( ) Yes ( )	Urinary urgency	No ( ) Yes ( )
Painful intercourse	No ( ) Yes ( )	Vaginal discharge	No ( ) Yes ( )
History of Infertility	No ( ) Yes ( )	Vaginal itching	No ( ) Yes ( )

***PLEASE CONTINUE...TURN* OVER**

10801 LOCKWOOD DR, # 310 / 320 SILVER SPRING, MD 20901 301.681.3400 P 301.681.7982 F
19851 OBSERVATION DR. # 345 GERMANTOWN, MD 20876 301.681.3400 P 240.912.7216 F

GYN HISTORY:

	COMMENTS
BREAST DISORDER No ( ) Yes ( )	
ABNORMAL PAP No ( ) Yes ( )	
OVARIAN CYST / MASS No ( ) Yes ( )	
UTERINE FIBROIDS No ( ) Yes ( )	
INFERTILITY TREATMENTS	
GONORRHEA____ CHLAMYDIA ____ No ( ) Yes ( )	
HERPES___ HPV / GENITAL WARTS___ No ( ) Yes ( )	
HIV___ SYPHILLIS___ No ( ) Yes ( )	
DOES YOUR PARTNER HAVE A HISTORY OF HERPES No ( ) Yes ( )	

OB / PREGNANCY HISTORY ( ) No Past Pregnancies

DATE	VAGINAL	C-SECTION	ANESTHESIA	WEIGHT OF BABY	LOCATION OF BIRTH	DELIVERING DOCTOR	COMPLICATIONS

MISCARRIAGES, ECTOPIC PREGNANCIES OR TERMINATIONS

DATE	MISCARRIAGE	TERMINATION	ECTOPIC	COMPLICATIONS

MEDICAL HISTORY: Do you currently have or have you been diagnosed with:

BLEEDING / CLOTTING DISORDER	No ( ) Yes ( )
HEART DISEASE	No ( ) Yes ( )
HYPERTENSION	No ( ) Yes ( )
DIABETES	No ( ) Yes ( )
THYROID DISEASE / DISORDER	No ( ) Yes ( )
LUNG DISEASE (ASTHMA, PNEUMONIA, TB	No ( ) Yes ( )
NEUROLOGICAL DISEASE / DISORDER (STROKE, SEIZURES, MIGRAINES	No ( ) Yes ( )
KIDNEY OR URINARY TRACT	No ( ) Yes ( )
GASTROINTESTINAL / LIVER DISEASE	No ( ) Yes ( )
VARICOSE VEINS / PHLEBITIS	No ( ) Yes ( )
DEPRESSION (INCLUDING POSTPARTUM)	No ( ) Yes ( )
PSYCHIATRIC DISORDERS	No ( ) Yes ( )
OTHER	No ( ) Yes ( )

PAST SURGICAL HISTORY ( ) No Surgical History **I need copy of detailed document if you want it included**

SURGERY	DIAGNOSIS	YEAR	SURGEON	COMPLICATIONS

Have you ever experienced complications from Anesthesia **NO ( ) Yes ( )**

explain: _____

FAMILY HISTORY (please check the appropriate columns)

	Mother	Father	Sister	Brother	Other	Age onset or death	Comments
ALIVE AND WELL							
DECEASED							
BLEEDING / CLOTTING DISORDER							
CORONARY ARTERY DISEASE /HEART ATTACK							
HYPERTENSION OR STROKE							
DIABETES							
OSTEOPOROSIS							
THYROID DISEASE							
BREAST CANCER							
UTERINE CANCER							
OVARIAN CANCER							
COLON CANCER							
OTHER							

HEALTH MAINTENANCE AND HISTORY

TEST	DATE	NORMAL	ABNORMAL	
LAST PAP TEST				---
MAMMOGRAM				
OSTEOPOROSIS TEST (DEXA OR BONE DENSITY SCAN)				
COLONOSCOPY To be repeated in ____ yrs				

NUTRITION: Calcium supplement No ( ) Yes ( ) Vitamin D No ( ) Yes ( )

SOCIAL HISTORY ( ) MARRIED ( ) SINGLE ( ) WIDOW ( ) DIVORCED

- Are you currently sexually active ? No ( ) Yes ( ) With a: Man ( ) Woman ( ) Both ( )
- How many sexual partners do you currently have? _____ during your lifetime? _____

EXERCISE: TYPE _____ **FREQUENCY** _____

TOBACCO USE: CURRENT: No ( ) Yes ( ) FORMER: No ( ) Yes ( ) NEVER ( )

TYPE_____ PACKS / DAY _____ YEARS SMOKED _____ Passive Smoke Exposure _____

ALCOHOL USE: CURRENT: No ( ) Yes ( ) FORMER: No ( ) Yes ( ) NEVER ( )

AVERAGE DRINKS/WEEK _____ TYPE _____ AMOUNT _____

YEARS QUIT _____ LAST DRINK _____

CAFFEINE USE: CURRENT: No ( ) Yes ( ) TYPE _____ AMT DAILY_____

HISTORY OF DOMESTIC VIOLENCE (CONFIDENTIAL):

ARE YOU A VICTIM OR SURVIVOR OF PHYSICAL OR SEXUAL ABUSE No ( ) Yes ( )

MEDICATIONS ( ) NO MEDICATIONS (be sure to include over the counter meds and supplements) ... for MD review

NAME (BRAND OR GENERIC)	DOSAGE	HOW OFTEN	START DATE	NAME OF PRESCRIBING PHYSICIAN

ALLERGIES ( ) No Known Allergies **... for MD review**

MEDICATION ALLERGY	REACTION
Latex Allergy NO ( ) YES ( )	

PHARMACY

NAME	LOCATION / ADDRESS	PHONE NUMBER

Do you want Sexually Transmitted Diseases testing (STDs) ?	**No ( ) Yes ( )**
I request testing for: (please check) ____ Gonorrhea ____ Chlamydia	*Chlamydia and Gonorrhea* are two of the most commonly transmitted STDs in the US. • *Symptoms* can include: Discharge, irregular bleeding, abnormal or pelvic pain, painful intercourse, vague bladder symptoms or they may be "silent" with no symptoms at all. • *Testing:* a sample is taken from the cervix, similar to a PAP smear. • *Cost:* ranges from $75- $125, depending on the lab your insurance requires us to use, and **MAY or MAY NOT** be covered by the insurance
I request testing for: (please check) ____ Syphillis ____ Hepatitis B /C ____ HIV	• *Syphyllis, Hepatitis B / C and HIV (Aids Virus)* can be tested with a blood sample. • Your insurance **MAY or MAY NOT** cover the test.
Please sign here to authorize this testing:	***DATE:***

Thank you for taking the time to share this valuable information concerning your health.

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