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

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

DATE _____ NAME _____
Last First Middle Initial Nickname

DOB _____ AGE _____ EMAIL _____

PATIENT'S OCCUPATION _____

PRIMARY CARE PHYSICIAN _____

REFERRING PHYSICIAN _____

GYN HISTORY REASON FOR VISIT: _____

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 (Every how many days)? _____ • Periods lasts _____number of days • Please list any issues with cycle: --- --- ---	Left or Right Breast (please circle one) • 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 ___	Calcium supplements? No ___ Yes ___ Vitamin D Supplements? No ___ Yes ___
Hormone Replacement Therapy? No ___ Yes ___	HRT medications:	Years taken:

TURN OVER

HISTORY / ADDITIONAL SYMPTOMS

Abnormal Bleeding	No__ Yes__	Last Pap: _____
Abnormal Pap	No__ Yes__	Last Mammogram: _____
Abnormal Mammogram	No__ Yes__	Last Dexa Scan (If Applicable): _____
Abnormal Vaginal Discharge	No__ Yes__	Last Colonoscopy (If Applicable): _____
Anxiety / Depression	No__ Yes__	
Ovarian Cysts	No__ Yes__	
Painful Intercourse	No__ Yes__	
Sexual Concerns	No__ Yes__	
Sexually Transmitted Infections(if yes please specify) _____		
Urinary Symptoms	No__ Yes__	
Uterine Fibroids	No__ Yes__	
Vaginal Itching	No__ Yes__	

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 ( )
DEPRESSION / PSYCHIATRIC (INCLUDING POSTPARTUM)	No ( ) Yes ( )
OTHER	No ( ) Yes ( )

MEDICATIONS ( ) NO MEDICATIONS (please include over the counter meds and supplements)

NAME (BRAND OR GENERIC)	DOSAGE	HOW OFTEN	REASON FOR MEDICATION

ALLERGIES ( ) No Known Allergies

MEDICATION ALLERGY	REACTION
Latex Allergy NO ( ) YES ( )	

PHARMACY

NAME:	ADDRESS:

TURN OVER

OB / PREGNANCY HISTORY ( ) No Past Pregnancies

DATE	VAGINAL OR C-SECTION	BABY SEX	WEIGHT OF BABY	ECTOPIC	MISCARRIAGE	TERMINATIO N	COMPLICATIONS

PAST SURGICAL / PROCEDURE HISTORY ( ) No Surgical History

SURGERY / PROCEDURE	DIAGNOSIS	YEAR	SURGEON	COMPLICATIONS

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

Please Explain: _____

FAMILY HISTORY (please check the appropriate columns)

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

NUTRITION: Calcium Supplement No__ Yes__ Vitamin D No__ Yes__ MULTI VITAMIN No__ Yes__

SOCIAL HISTORY: SINGLE__ DIVORCED__ ENGAGED__ MARRIED__ WIDOW__

- Are you currently sexually active? No__ Yes__ With a: Man__ Woman__ Both__

TURN OVER

- What is your current gender identity? (Check all that apply)
  - Female
  - Male
  - Transgender Male/Transman/FTM
  - Transgender Female/Transwoman/MTF
  - Additional Category (Please specify): _____
  - Decline to answer
- What pronouns do you prefer that we use when talking to you?
  - Please specify: _____

EXERCISE: TYPE _____ **FREQUENCY:** _____

ALCOHOL USE: _____ **FREQUENCY:** _____

TOBACCO USE: CURRENT: No__ Yes__ (Packs Per Day: _____) FORMER: No__ Yes__

CAFFEINE USE: CURRENT: No__ Yes__ TYPE _____ AMT DAILY_____

RECREATIONAL DRUGS: CURRENT: No__ Yes__ (Type: _____) FORMER: No__ Yes__

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) Syphilis | Hepatitis | HIV ___	• *Syphilis, 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:***

PATIENT SIGNATURE_____ **DATE**_____

PROVIDERS SIGNATURE_____ **DATE**_____

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

TURN OVER

Hereditary Risk Assessment

Name: _____ Date of Birth: _____ Date: _____

Based on the information you provide here, you MAY be appropriate for genetic testing and your provider may be able to change your medical management to improve your care. Include the following blood relatives on both your mother's and father's side of the family: **parents, siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews.**

Do you think you may become pregnant in the next 2 years? Yes No Maybe N/A

Have you had hereditary cancer genetic testing? Yes No Unsure

If YES, results were: ☐ Negative ☐ Positive, Gene:_____

➔ **IF YOU ANSWERED 'YES' AND HAVE ALREADY HAD MYRISK CANCER GENETIC TESTING, PLEASE STOP HERE** STOP

Have YOU ever been diagnosed with the following:			**Which Cancer:**	**Age of Diagnosis**
Breast, ovarian, pancreatic or colon/rectal cancer at any age	Yes	No		
Uterine/endometrial cancer before age 65	Yes	No		

Have your relatives ever been diagnosed with the following:			**Which Relative(s):** (Write 'M'=Maternal or 'P'=Paternal)	**Age of Diagnosis**
Breast cancer at age 49 or younger	Yes	No		
Ovarian cancer at any age	Yes	No		
Breast cancer in both breasts (bilateral) at any age	Yes	No		
3 breast cancers on the same side of the family at any age	Yes	No		
Male breast cancer at any age	Yes	No		
A first degree relative (parent, sibling or child) with colon or uterine cancer before age 50	Yes	No		
A first degree relative (parent, sibling or child) with pancreatic cancer OR metastatic prostate cancer at any age	Yes	No		
3 or more of the following cancers on the same side of the family at any age: uterine, colon, stomach	Yes	No		
Jewish ancestry with one or more breast cancer in the family	Yes	No		

Have any relatives been tested for genes that cause cancer? Yes No If yes, explain:_____

Patient Signature: _____ **Provider you are seeing today:** _____

FOR OFFICE USE ONLY

Patient is a candidate for genetic testing: **Yes** **No**

___ Patient accepted ___ Patient declined

___ Patient will confirm hx with relatives ___ Genetic testing information provided PROVIDER INITIALS: _____