Capital Women's Care

Division 44

Rockville & Germantown

www.dmvobgyn.com

Patient Information Questionnaire

Name:_____ **DOB:**_____ **Today's date:** _____

Reason for visit:_____ **Preferred pharmacy:** _____

Primary Care Provider:_____ **Who Referred you to our practice:** _____

Latex Allergy? Yes___No___ **List Allergies/Reaction:** _____

_____

Current Medications: _____

_____

First day of last menstrual cycle:_____or **Age of Menopause:**_____(Do you take hormones? Yes___No___)

Age at first menstrual cycle:_____ **Cycle Duration:**_____Days **Last pap smear:** _____

Last mammogram:_____ **Last Bone Density Test (DEXA):**_____ **Last colonoscopy:** _____

Have you received your HPV vaccination series? No_____Yes_____Dates:_____

Current method of contraception (birth control): _____

# of Pregnancies_____: Indicate Number for Each of the Following

Full Term	Preterm	Miscarriages	Terminations	Ectopic	Living Children	C-Section	Vaginal Del

Marital Status: Single ___Married ___Divorced ___Widow___ **Sexual Orientation:** _____

Highest Level of Education (Circle One): High School Some College College Grad Tech School Med School

Employer:_____ **Occupation:** _____

Medical History: Please check any of the following that apply to ***YOU***

- ☐ Abnormal Pap
- ☐ Anemia
- ☐ Anesthesia complications
- ☐ Anxiety
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bartholin's gland cyst
- ☐ Blood transfusion
- ☐ Breast Cancer
- ☐ Breast Mass
- ☐ Bronchitis
- ☐ Bruising/bleeding disorder
- ☐ Blood clotting disorder
- ☐ Cervical Cancer
- ☐ Chronic back pain
- ☐ Congenital heart defect
- ☐ Cystocele
- ☐ Depression
- ☐ DES exposure
- ☐ Diabetes
- ☐ Drug/Alcohol use
- ☐ Endometriosis
- ☐ Fibroids in uterus
- ☐ Gallbladder disease
- ☐ Genital Herpes
- ☐ Gastric Reflux
- ☐ Headaches/Migraines
- ☐ Heart Attack
- ☐ Heart murmur
- ☐ Hepatitis/Liver disease
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Infertility
- ☐ IBS
- ☐ Phlebitis
- ☐ Obesity
- ☐ Ovarian Cancer
- ☐ Ovarian Cyst
- ☐ PID
- ☐ Pneumonia
- ☐ Polycystic ovaries
- ☐ Psychiatric disease (OCD, panic attack, bipolar)
- ☐ Pulmonary embolism
- ☐ Seizure disorder
- ☐ Skin Cancer
- ☐ Skin Disorder (eczema, psoriasis)
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Uterine Cancer
- ☐ UTI, recurrent
- ☐ Vaginal infections
- ☐ STD
- ☐ Other: _____

Review of Systems: Please check any recent (within 6 months) or current issues you have

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Visual changes
- ☐ Breast concerns (pain, mass/lump, discharge)
- ☐ Unintentional weight gain or loss
- ☐ Nausea/vomiting/diarrhea/constipation
- ☐ Pain with urination
- ☐ Ringing of the ears
- ☐ Muscle weakness
- ☐ Other: _____

Surgical History: Include elective procedures & attach additional paper if needed

Date of Surgery:	Type of Surgery:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History:

Please indicate the family member by putting a check mark in the box. If the family member is someone other than those listed please indicate maternal or paternal (aunt, uncle, grandmother or grandfather).

Diagnosis:	Mother	Father	Sister	Brother	Other	Other
Alive and Well						
Deceased (indicate cause)						
Alcoholism						
Asthma						
Autoimmune disorder						
Breast Cancer						
Cervical Cancer						
Coagulopathy (Blood clots)						
Colon Cancer						
Heart attack						
CAD/Heart Disease						
Stroke						
Depression						
Diabetes						
High Cholesterol						
High Blood Pressure						
Mental Illness						
Osteoporosis						
Ovarian Cancer						
Seizure disorder						
Skin Cancer						
Thyroid disease						
Other _____						

Tobacco Use: ☐ Never ☐ Current ☐ Former

Type: _____

Packs per day: _____

Years Smoked: _____

Caffeine Use: ☐ No ☐ Yes Type:____

Amount per day: _____

Alcohol Use: ☐ No ☐ Yes

☐ Former

Type:_____

Amount:_____

Frequency: _____

Last Drink: _____

Would you like to be screened for sexually transmitted diseases (STDs)? YES or NO

Chlamydia and Gonnorrhea are two of the most common transmitted baterial STD's in the United States. These infections may present discharge, irregular bleeding, abdominal or pelvic pain, painful intercourse or they may be silent with no symptoms at all. If you request testing, a sample is taken from cervix similar to pap smear. Other STD's such as syphillis, hepatitis and HIV can be tested with blood samples. The cost of these depends on the lab your insurance company requires us to use and may not be covered.

Provider Signature_____Date _____