



CAPITAL WOMEN'S CARE

Obstetrics & Gynecology

1165 IMPERIAL DRIVE, SUITE 300
HAGERSTOWN, MD 21740

WWW.CWCHAGERSTOWN.COM

PHONE: 301-665-9098
FAX: 301-665-9096

Dear Patient:

It is with pleasure that we welcome you to Capital Women's Care. To help your visit go as smoothly as possible, please assist us by bringing the following with you:

- Please complete all documents in this packet.
- Current insurance card(s) and Drivers License or Photo ID must be presented upon arrival.
- Insurance referral form, if necessary.
- Co-payments are collected upon arrival. We accept cash, check, American Express, Visa, MasterCard, and Discover.
- Please arrive 20 minutes before your scheduled appointment time to complete the necessary registration information.
- **Missed Appointment Policy:** We respectfully request that you cancel your scheduled appointment by phone 24 hours in advance. Your cooperation and consideration is appreciated.

Important Reminders

- Capital Women's Care is located in Suite 300 (3rd floor) 1165 Imperial Dr., Hagerstown, MD 21740.
- We participate with many insurance companies. If your insurance company requires a referral it is your responsibility to obtain the referral. The referral must be presented at the time of your appointment. This office cannot provide treatment if the required referral has not been obtained. If you do not have your insurance referral form at the time of your appointment we reserve the right to cancel and reschedule your appointment or you may pay in full at the time of service.
- Please notify our office if there are any changes to the following information: Home Address, Telephone number(s) or Insurance information.
- The charge for completion of forms is \$10.00. Forms will be completed with 7-10 business days.
- Release of Medical Records: We will need you to complete a signed authorization for the release of medical records. Please allow five business days for the processing of medical records. Please contact the office for more information about the cost of copying medical records.
- **Late Arrivals:** If you are 15 minutes late for your appointment, we will do our best to accommodate you but it may be necessary to reschedule your appointment.

Sincerely,

The Staff of Capital Women's Care

Capital Women's Care
1165 Imperial Drive, Suite 300
Hagerstown, MD 21740
www.cwchagerstown.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*

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

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Breast concerns (pain, mass/lump, discharge) | <input type="checkbox"/> Pain with urination |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Unintentional weight gain or loss | <input type="checkbox"/> Ringing of the ears |
| <input type="checkbox"/> Visual changes | <input type="checkbox"/> Nausea/vomiting/diarrhea/constipation | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> 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

	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: _____

Provider Signature _____ Date _____

OB History Addendum

Name: _____ DOB: _____

Name of partner or support person: _____

Name of the father of the baby (if different from above): _____

Preferred pediatrician (if known): _____

Do you plan to breast or bottle feed (Circle One)? BREAST BOTTLE BOTH

Are you interested in birth classes (childbirth education, infant CPR, breastfeeding)? Yes ___ No ___

Have you or your significant other traveled outside of the US within 3 months prior to or during your pregnancy?

No ___ Yes ___ Dates & Location(s) Traveled _____

Pregnancy History Details: (attach additional paper if needed)

Month/Year/ Duration of pregnancy	Type of delivery: vaginal, c-section, miscarriage, abortion	Baby's weight	Baby's name/sex	Place of delivery/delivering doc or midwife	Complications

Genetic/Ethnic History: Include and list all family history for yourself and father of the baby

Disease	✓ If Yes	Person Affected
Thalassemia (Italian, Greek, Mediterranean, Asian background)		
Neural Tube Defects (spina bifida, anencephaly, meningomyelocele)		
Cleft Lip or Cleft Palate		
Downs Syndrome		
Tay-Sachs		
Sickle cell disease or trait		
Heart Birth Defect (congenital heart defect)		
Hemophilia		
Developmental Delay		
Muscular Dystrophy		
Cystic Fibrosis		
Huntington's Chorea		
Mental retardation/autism		
African-American, Jewish or French Canadian Background		

Please list any additional genetic disorders or birth defects not listed above along with the person affected: