CAPITAL WOMEN'S CARE®

"Working Together for Women's Health"

ANNE B. BROWN, M.D., F.A.C.O.G.
JANE D. ALLEN, M.D., F.A.C.O.G.
CATHLEEN S. MILLS, M.D., F.A.C.O.G.
GILLIAN A. JACOB, M.D., F.A.C.O.G.

GYN RETURN PATIENT ANNUAL FORM Date: ___/___/___

Patient Name: _____ DOB: ___/___/___

First Day of Last Period: ___/___/___ Preferred Pharmacy: _____

Method of Contraception: **Pills/Condoms/Patch/Ring/IUD/Tubal/Vasectomy/Abstinence/Other:**_____

Primary Care Physician: _____ Current/Former Smoker? ***Yes/No***

Tobacco Use: ____ cigarettes/day for __ years Other Tobacco Use? _____

Alcohol Use: ___ servings per day/week/month

Medications (including over-the-counter, herbals, supplements, and herbs):

Allergies to medications and/or Latex (please include reaction):

Changes in Medical/Surgical History:

Changes in Family History:

Does anyone in your family have a history of Breast, Ovarian, or Colon Cancer?_____
*If yes, who and at what age?*_____

Have you had a colonoscopy? ***Yes/No*** When? ___/___/___ Was it normal? ***Yes/No***

Have you had a bone density test? ***Yes/No*** When? ___/___/___ Was it normal? ***Yes/No***

Have you had a Mammogram? ***Yes/No*** When? ___/___/___ Was it normal? ***Yes/No***

Have you ever had an abnormal pap smear or tested positive for HPV? ***Yes/No*** When? ___/___/___

If you are age 65 or older, have you had a pneumonia vaccine? ***Yes/No*** When? ___/___/___

Please list the main reason for your visit today: _____
_____

Please let us know if you have any of the following symptoms: fatigue, fever, weight gain/loss, hearing loss, visual changes, short of breath, cough, chest pain, edema, abdominal pain, blood in stool, nausea/vomiting, discomfort when urinating, leaking urine, painful periods, painful intercourse, irregular periods, vaginal discharge, breast lump, skin lesion, hair changes, headaches, seizures, anxiety, depression, insomnia, cold/heat intolerance, back pain, joint pain, easy bleeding or bruising, food allergies, seasonal allergies, other:_____

Provider Signature:_____ **Date**: ___/___/___

PLEASE BE ADVISED THAT IF ANY PROBLEMS ARE DISCUSSED DURING YOUR WELL WOMAN VISIT YOUR INSURANCE WILL BE BILLED FOR THE PROBLEM. YOU COULD BE RESPONSIBLE FOR A COPAY, COINSURANCE, OR DEDUCTIBLE. THANK YOU.

Updated 08/11/16

HEREDITARY CANCER HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____

Important: Only consider 1st or 2nd degree relatives when answering the questions below (unless otherwise stated)
1st Degree - Parents, Siblings, Children
2nd Degree - Grandparents, Aunts/Uncles, Nieces/Nephews, Half-Siblings

PLEASE CIRCLE YES OR NO			Which Relative (s)	Maternal or Paternal	Which Cancer(s)	Age of Diagnosis
NO	**YES**	Have YOU ever been diagnosed with breast or ovarian cancer?	-------	-------		
NO	**YES**	Were YOU diagnosed with colon or uterine cancer at age 49 or younger?	-------	-------		
NO	**YES**	**Do you have a relative diagnosed with breast cancer at age 49 or younger? ***			-------	
NO	**YES**	Do you have a 1st or 2nd degree male relative diagnosed with breast cancer?			-------	
NO	**YES**	**Do you have 3 or more relatives diagnosed with breast cancers on the same side of the family? ***	1. 2. 3.	1. 2. 3.	-------	1. 2. 3.
NO	**YES**	**Do you have a relative diagnosed with ovarian cancer? ***			-------	
NO	**YES**	Do you have a 1st degree relative diagnosed with pancreatic cancer?			-------	
NO	**YES**	Are you of Ashkenazi Jewish ancestry and have a relative diagnosed with breast cancer?			-------	
NO	**YES**	Do you have 3 or more relatives diagnosed with colon or uterine cancers on the same side of the family?	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.

*Meets Affordable Care Act Criteria

FOR OFFICE USE ONLY

- ☐ Patient is NOT appropriate for testing
- ☐ Patient is appropriate for testing
- ☐ Patient offered genetic testing: ACCEPTED or DECLINED

HCP Signature:_____ Date:_____