CAPITAL WOMEN'S CARE

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.
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Alaina Wayland, PA-C

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:**_____

PCP: _____

Would you like a chaperone during your intimate exam today? ***Yes / No***

Tobacco use: Current/ Former/ Never
Cigarette use: ____ cigarettes per day for ___ years
Other Tobacco use: _____

Alcohol use: ___ servings per day/ week/ month

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

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

Changes in Medical/Surgical History:

Changes in Family History:

Do you have a family history of Breast, Ovarian, Uterine, Prostate, or Colon Cancer?_____

*If yes, who and at what age(s)?*_____

Please list the main reason for your visit today: _____

_____

Please Complete The Other Side →

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 02/23/2024

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Have you had the following:

		When?	**Result** *(normal/ abnormal/ treatment needed)*
Colonoscopy	Yes / No		
Bone Density (DEXA)	Yes / No		
Mammogram	Yes / No		
Abnormal PAP, HPV positive	Yes / No		
Pneumonia vaccine (65+ years old)	Yes / No		-------

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things.	0	1	2	3
Feeling down, depressed, or hopeless.	0	1	2	3
Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
Feeling tired or having little energy.	0	1	2	3
Poor appetite or overeating.	0	1	2	3
Feeling bad about yourself – or that you are a failure or have left yourself or your family down.	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score to each column				

Total Score (add column score) _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely difficult**

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

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