



CAPITAL
WOMEN'S
CARE

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GYN RETURN PATIENT INFORMATION 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: _____ 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.