CAPITAL WOMEN'S CARE

Obstetrics & Gynecology

CHRISTOS BALLAS, M.D., F.A.C.O.G.
MICHAEL BARNETT, M.D., F.A.C.O.G.
STEVEN MILLER, M.D., F.A.C.O.G.
DEE HUBBARD, M.D., F.A.C.O.G.

844 WASHINGTON ROAD SUITE 302
WESTMINSTER, MD 21157
WWW.CWCCARROLLCOUNTY.COM
PHONE: 410-876-2003
FAX: 410-848-3009

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:

- All documents in this packet **must be completed** and signed before the day of your appointment. If not completed your appointment will need to be rescheduled.
- **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. If you are unable to make your payment, your appointment will need to be rescheduled.

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. If you do not cancel by the deadline, you may be assessed a $35.00 missed appointment fee. This fee is not covered by insurance carriers and it will be your responsibility to pay. Our aim here is to open otherwise unused appointments for our patients, not to collect missed appointment fees. Your cooperation and consideration is appreciated.

Important Reminders

- Capital Women's Care is located in Suite 300 (3rd floor) 844 Washington Road, Westminster, MD 21157.
- We participate with many insurance companies. Please confirm the participation of our providers with your insurance company. 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). Insurance Information.
- The charge for completion of forms is $10.00. Forms will be completed within two weeks.
- 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 or we cannot complete the required administrative preparation for your appointment without delaying the other patients, it may be necessary to appoint you another time.

Your appointment is scheduled for _____ at _____

with _____. **Please arrive at** _____.

Sincerely,

The Staff of Capital Women's Care

Capital Women's Care
844 Washington Road, Suite 302
Westminster, MD 21157
www.cwccarrollcounty.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: _____

Provider Signature _____ Date _____