Mid Atlantic
Gynecologic Oncology and Pelvic
Surgery Associates

Annette Bicher, M.D.
John C. Elkas, M.D., J.D.
Ruchi Garg, M.D.
G. Scott Rose, M.D.
Chad Hamilton, M.D.
Elise McManaman, MSN, WHNP-BC
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Fairfax Office:
8081 Innovation Park Dr., Ste 775
Fairfax, VA 22031-4867
Phone: 571-308-1830
Fax: 571-308-1843
www.magopsa.com

Dear Patient,

In order to update our Electronic Medical Records, we would like to obtain additional personal information that is not currently on our patient profile form to comply with the meaningful use guidelines.

Please provide us with the answers to the three additional questions below to complete your registration process within our system.

Patient Name: _____ DOB: _____

1. Preferred language: _____
2. Race:
   - ❑ American Indian or Alaska Native
   - ❑ Asian
   - ❑ Black or African American
   - ❑ Native Hawaiian or Other Pacific Islander
   - ❑ White
3. Ethnicity:
   - ❑ Hispanic
   - ❑ Non-Hispanic

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Name:	**Birthdate:**
Marital Status:	**Occupation:**
Reason for visit:	**Employer:**
Referred by:	**Primary Care Physician:**
Other Physicians:	
List drug allergies:	

FAMILY HISTORY

Specify **ANY** relative with the following conditions

	LIVING Relationship	DESEASED Relationship
Cancer: Breast		
Ovaries		
Uterus		
Colon		
Lung		
Other		
Diabetes:		
Heart Attack:		
High Blood Pressure:		
Stroke:		
Epilepsy:		
Kidney Disease:		
Emotional Problems:		
Asthma:		
Migraine:		

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD

❑ Hypertension	❑ Back Problems
❑ Diabetes	❑ Broken Bones
❑ High Cholesterol	❑ Skin Problems
❑ Glaucoma	❑ Breast Diseas
❑ Cataract	❑ Stroke
❑ Heart Disease	❑ Head Injury
❑ Murmur	❑ Seizures
❑ Vascular Disorders	❑ Depression
❑ Asthma	❑ Substance Abuse
❑ Lung Disease	❑ Thyroid Disorder
❑ Kidney Disease	❑ Bleeding Disorder
❑ Bladder Problems	❑ Blood Clots
❑ Bowel Problems	❑ Blood Transfusion
❑ Gallbladder Disease	❑ Anemia
❑ Liver Disease	❑ Cancer
❑ Hepatitis, Jaundice	❑ Yeast
❑ Ulcers	❑ Chlamydia
❑ Others:	❑ Others:

HABITS

Do you smoke?	How much: _____ How many years: _____
Do you drink alcohol?	How much: _____ How often: _____

Do you take drugs?	How often:
Do you drink coffee?	How much:

SURGERIES

Appendix:	Breast:
Gall Bladder:	Tumors:
Tonsils:	Hemorrhoids:
Kidney Stones:	C-Section:
Hernia:	Ovaries:
Spine:	Uterus:
Other:	Other:

GYNECOLOGIC HISTORY

Age at onset of menstrual period: _____
Date of last period: _____
Period comes every _____ days
Flow: Heavy ☐ Medium ☐ Light ☐
Date of last Pap Smear: _____
Method of contraception: _____
# of sexual partners in the last 6 months: _____
# of pregnancies _____ # of miscarriages _____
# of live births _____ # of abortions _____
# of live children _____
Date of last Mammogram: _____
Do you perform monthly breast exams?
Yes ☐ No ☐
Abnormal Pap Smears:
Genital Warts ☐ Vaginitis ☐ Herpes ☐
Trichomonas ☐ Gonorrhea ☐ Syphilis ☐

Reviewed by: _____ **Date:** ___/____/_____

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Patient Name: _____ **Age:** _____ **DOB:** _____

Please list any problems you would like to talk about or be examined for:

1. _____
2. _____
3. _____
4. _____

Please check any of the following problems you have or recently had:

(Established patients please check problems since your last visit to this office)

☐ Irregular Periods	☐ Dry Mouth	☐ Frequent Urination	☐ Headaches
☐ Change in Menstrual Flow	☐ Problem Swallowing	☐ Urinary Urge	☐ Weakness
☐ Bleeding Between Periods	☐ Palpitations	☐ Painful Urination	☐ Numbness
☐ Bleeding during/after Sex	☐ Chest Pain	☐ Nightly Urination	☐ Mood Changes
☐ Painful Menstruations	☐ Swelling of Feet and Arms	☐ Involuntary Urine Loss	☐ Sleep Problems
☐ Pain with Sexual Intercourse	☐ Loss of Consciousness	☐ Bloody Urine	☐ Lack of Energy
☐ Vaginal Discharge	☐ Shortness of Breath	☐ Joint Aches, Pain	☐ Depression
☐ Vaginal Dryness	☐ Chronic Cough	☐ Joint Swelling	☐ Memory Loss
☐ Hot Flashes	☐ Bringing Up Mucus	☐ Muscle Aches, Pain	☐ Feel Hot or Cold
☐ Change in Sexual Desire	☐ Constipation	☐ Rash	☐ Usually Thirsty
☐ Fever	☐ Diarrhea	☐ Skin Lesions	☐ Easy Bruising
☐ Weight Loss	☐ Bloating	☐ Breast Lumps	☐ Easy Bleeding
☐ Weight Gain	☐ Abdominal Cramps, Pain	☐ Breast Tenderness	☐ Swollen Lymph Glands
☐ Change in Appetite	☐ Blood in Stool	☐ Nipple Discharge	☐ Other:
☐ Blurred Vision	☐ Nausea or Vomiting	☐ Other:	☐ Other:
☐ Double Vision	☐ Heartburn	☐ Other:	☐ Other:
☐ Eye Problems	☐ Other:	☐ Other:	☐ **All blanks are negative**

FOR ESTABLISH PATIENTS ONLY		
Last Menstrual Period:	Last Pap:	Last Mammogram:
Last Colon Exam:	Last Chest X-Ray:	
Referred by:	**Primary Care Physician:**	**Other Physicians:**

Please list illnesses, surgeries, hospitalization and new allergies since your last visit: _____

_____

_____

Please list NEW medications and those you stopped since your last visit:

NEW	STOPPED

Please list changes in marital status, employment, drug use: _____

_____

Please list cancer diagnosed in your family since your last visit: _____

_____

Reviewed by: _____ **Date:** ____/____/_____

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