The GW Medical Faculty Associates

Welcome to Medical Faculty Associates OBGYN of Greater Washington

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We would like personally welcome you and express our appreciation that you have chosen our practice to provide your medical needs. We are a member of GW Medical Faculty Associates. If you are an established patient, we thank you for continuing to choose us as you health care provider.

Core Office Hours

Monday-Friday: 830 AM – 5:00 PM

Calls received after normal hours will be answered be our answering service and forwarded to the on-call physician. If you are having a medical emergency, **CALL 911 IMMEDIATELY.**

Office Locations:

Rockville: 11500 Old Georgetown Road, Rockville, MD 20852 Phone: 301-468-4900

Germantown: 19785 Crystal Rock Drive, Suite 208, Germantown, MD 20874 Phone: 301-528-8444

General Office Fax: 301-540-3260

Website: Rockvilleobgyndoctor.com

Insurance & Billing Issues:

We accept most insurances and claims are filed through GW MFA. For billing inquiries, please call the GW MFA Business Office: 202-741-3560. Customer Service hours are from 9:00 AM-9:00PM Monday-Friday and 9:00 AM-1:00 PM on Saturdays. If you are NOT covered by insurance you will be considered a self pay patient.

Co-Payments, Deductibles, Coinsurance and Outstanding Balances:

All patients are responsible for any outstanding balances as well as copays, coinsurances and charges for services rendered at the time of their appointment. For your convenience, we accept payment by cash or credit/debit card.

Same Day Appointments:

It is our goal to provide you with high quality, convenient medical care by caring staff. There are times however, that it may be difficult to get an appointment on the "same day". We encourage you to call **before 11 AM** during our office hours to schedule an appointment. Generally speaking routine visits and physical examinations are not scheduled at times reserved for urgent "same day" appointments. Unscheduled walk-in visits are highly discouraged as you may have a very long waiting period before you can be seen, or you may be asked to schedule your appointment on another day.

The GW Medical Faculty Associates

Active OB Practice:

We are an active OB practice. This means we might have to cancel or reschedule your appointment if there is a patient in labor and the doctor you are seeing is on call. We will try our best to accommodate your appointment with another doctor, if they are available the same day. If not, we might have to reschedule for another day.

Cancellation, Missed and Late Arrivals for Appointments:

We utilize an automated calling system that will call you to remind you of your appointment. There will be 2 reminders for each appointments, 14 days before and 3 days before your appointment. We would appreciate the courtesy of a 24 hour advance notice to cancel an appointment. Please let us know as soon as possible if you are going to be late or cancel the appointment.

Demographics:

It is important for us to be able to reach you to provide optimal care. Please understand that we have you sign a demographic form EVERY visit, to make sure your information is up to date. PLEASE make sure to look at EVERY line to make sure it's up to date.

Obtaining a Referral for Specialist Care:

If your insurance requires a referral from your primary care physician, please be aware that it is YOUR responsibility to bring one to your appointment.

Medical Forms:

We will complete forms for patients who have been seen by the physician in the past 6 months. New Patients ans others who haven't been seenin the past 12 months are required to make an appointment and be seen by the provider before any forms will be completed. Please allow 5-7 business days for completion. **There is a $25 fee for ALL forms to be filled out.**

Prescription Refills:

Please call your pharmacy regarding refills on medication **at least 72 hours (3 Days) in advance** to allow sufficient time for the pharmacy, and for your physician to receive and respond to your request before you run out of your medication. For maintenance medication, your physician will normally provide refills to last until it is time for your next office visit. If you are out of refills, this may indicate that it is time for you to schedule an appointment with the physician.

Leaving messages for the Providers:

Please be aware when leaving messages for the providers, they are seeing patients throughout the day. They will call you back with a 24 hour period. If you are calling to get medication called in for a yeast infection, UTI, bacterial infection, you will be required to make an appointment. **We do not call in medication for these issues.**

The GW Medical Faculty Associates

We thank you for allowing us to participate in your health care and hope the above information will assist you in obtaining prompt and convenient medical care. Please sign below to show you have received a copy of your MFA OBGYN of Greater Washington policies and we will supply you with a copy to take home for your future information.

Name: _____

Patient/Guardian Signature: _____ Date: _____

OBSTETRICS AND GYNECOLOGY
NEW PATIENT HISTORY

Name _____ Date of Birth _____ Today's date _____

Primary Care Physician _____

Preferred Pharmacy _____ Pharmacy address _____ Phone _____

Reason for today's visit _____

_____

Date of last menstrual period _____

OB HISTORY

	NUMBER		NUMBER		NUMBER
Pregnancies	_____	abortions	_____	miscarriages	_____
Premature births	_____	live births	_____	living children	_____

BIRTH DATE	TYPE OF DELIVERY	WEEKS PREGNANCY	BIRTH WEIGHT	BABY'S SEX

Pregnancy complications: diabetes ☐ high blood pressure ☐ other _____

History of depression before or after pregnancy? Yes ☐ No ☐ _____

GYN HISTORY

How old were you when you had your first period? _____

Are your cycles regular/monthly? Yes ☐ No ☐

How many days does your period last? _____

If in menopause, at what age did it occur? _____

Years of hormone replacement therapy? _____

Are you currently sexually active? Yes ☐ No ☐

If not, have you ever been sexually active? Yes ☐ No ☐

Do you currently have a partner? Yes ☐ No ☐ Partner's gender _____

How long have you been in this relationship? _____

How many lifetime sexual partners have you had? _____

At what age was your first intercourse? _____

Have you ever been sexually abused, threatened or hurt by anyone? _____

Are you experiencing any sexual problems? _____

When was your last pap smear? _____

Have you had any abnormal pap smears? Yes ☐ No ☐ when? _____

Have you been told you have HPV? Yes ☐ No ☐ when? _____

Have you had any treatments for abnormal pap smears? Yes ☐ No ☐ repeat pap colposcopy biopsy

Have you received HPV vaccine? Yes ☐ No ☐ date _____

Have you ever had ovarian cysts? Yes ☐ No ☐

Have you been told you have fibroids of the uterus? Yes ☐ No ☐

Have you ever been treated for any sexually transmitted infections? Yes ☐ No ☐

☐ Gonorrhea ☐ Chlamydia ☐ Syphilis ☐ Herpes ☐ Condyloma ☐ PID

Have you ever been tested for HIV? YES ☐ NO ☐ Date of last test? _____ Result? Neg ☐ Pos ☐

Current birth control

☐ None ☐ Timing ☐ Condoms ☐ Diaphragm ☐ Birth control pills ☐ Patch
☐ Implants ☐ Depo Provera ☐ IUD ☐ Tubal ligation ☐ Vasectomy ☐ Ring

Past birth control

☐ None ☐ Timing ☐ Condoms ☐ Diaphragm ☐ Birth control pills ☐ Patch
☐ Implants ☐ Depo Provera ☐ IUD ☐ Tubal ligation ☐ Vasectomy ☐ Ring

Have you ever had a yeast infection? Yes ☐ No ☐ Chronic? Yes ☐ No ☐

Have you ever been treated for a vaginal bacterial infection (bacterial vaginosis)? Yes ☐ No ☐ Chronic? Yes ☐ No ☐

Do you ever have problems with urinating such as infections, frequency, loss of urine, blood in your urine? Yes ☐ No ☐

If yes, please explain _____

When was your last mammogram? _____
Have you had any abnormal mammograms? Yes ☐ No ☐ _____
Have you had any breast biopsies? Yes ☐ No ☐ If yes, result _____
Do you do breast self examination? Yes ☐ No ☐

HEALTH MAINTENANCE

Procedure	date	results
Last bone density		
Last cholesterol		
Last colonoscopy		

MEDICAL HISTORY

Arthritis	yes ☐	no ☐	_____
Asthma	yes ☐	no ☐	_____
Chronic lung disease	yes ☐	no ☐	_____
Cancer	yes ☐	no ☐	_____
Diabetes	yes ☐	no ☐	_____
Eye disease	yes ☐	no ☐	_____
Heart disease	yes ☐	no ☐	_____
Hypertension	yes ☐	no ☐	_____
Kidney disease	yes ☐	no ☐	_____
Liver disease	yes ☐	no ☐	_____
Psychiatric disorder	yes ☐	no ☐	_____
Seizures/epilepsy	yes ☐	no ☐	_____
Stomach/intestinal disease	yes ☐	no ☐	_____
Stroke	yes ☐	no ☐	_____
Thyroid disease	yes ☐	no ☐	_____
Other			_____

SURGICAL HISTORY

List any surgeries you have had and the approximate date
Example: tonsillectomy, appendectomy, gallbladder, tubal ligation, breast surgery/biopsy, laparoscopy

_____

_____

_____

_____

Have you had a blood transfusion? Yes ☐ No ☐ if yes, when_____

FAMILY HISTORY

List any MEDICAL CONDITIONS of your relatives

Mother living/deceased _____

Father living/deceased _____

Siblings _____

			☐☐ Relationship to you
Diabetes	yes ☐	no ☐	_____
Hypertension	yes ☐	no ☐	_____
Thyroid disease	yes ☐	no ☐	_____
Cancer			
Breast	yes ☐	no ☐	_____
Ovarian	yes ☐	no ☐	_____
Colon	yes ☐	no ☐	_____
Other			_____
Psychiatric illness	yes ☐	no ☐	_____
Osteoporosis	yes ☐	no ☐	_____
Other	yes ☐	no ☐	_____

SOCIAL HISTORY

Occupation _____

Marital status single ☐ married ☐ separated ☐ divorced ☐ widowed ☐

Children _____

Pets _____

Tobacco	yes☐	no☐	quit☐	#cigarettes/day _____	#years	_____
Alcohol	yes☐	no☐	quit☐	#drinks per day/week _____	type	_____
Drugs	yes☐	no☐	quit☐	_____		
Exercise	yes☐	no☐	☐	#times/week _____	type	_____

Health care proxy yes☐ no☐

Seat belt use yes☐ no☐

MEDICATIONS (including over the counter medications and supplements)

Name	Dose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List any medications or foods that you are **ALLERGIC** to (and the reaction):

_____ _____

_____ _____

REVIEW OF SYSTEMS **Please circle all that are applicable (within the last 6-12 months)**

CONSTITUTIONAL
☐ Negative
☐ Fever
☐ Chills
☐ feeling poorly
☐ feeling tired
☐ recent weight gain
☐ recent weight loss

EYES
☐ Negative
☐ Eye Pain
☐ Wearing glasses
☐ spots before eyes
☐ vision changes
☐ dry eyes
☐ itchy eyes

EAR/NOSE/THROAT
☐ Negative
☐ Earaches
☐ Loss of hearing
☐ nose bleeds
☐ sinus problems
☐ sore throat
☐ dental problems

CARDIOVASCULAR
☐ Negative
☐ Chest pain
☐ Palpitations
☐ heart rate is fast
☐ heart rate is slow
☐ leg swelling (edema)

RESPIRATORY
☐ Negative
☐ Shortness of breath
☐ Wheezing
☐ cough
☐ dyspnea (shortness of breath) on exertion
☐ shortness of breath with lying flat (orthopnea)
☐ respiratory distress in sleep (PND)

GASTROINTESTINAL
☐ Negative
☐ Abdominal pain
☐ Vomiting
☐ Nausea
☐ constipation
☐ diarrhea
☐ early satiety
☐ heartburn
☐ black stool (melena)
☐ maroon colored stool (hematochezia)

OB/GYN GU
☐ Negative
☐ Frequency
☐ Nocturia
☐ Dysuria
☐ blood in urine
☐ cloudy urine
☐ odor in urine
☐ incomplete emptying of bladder
☐ stress incontinence
☐ urge incontinence

OB/GYN
☐ Negative
☐ Abnormal bleeding
☐ Irregular menses
☐ Pain with menses
☐ Pain with intercourse
☐ Anorgasmia
☐ vulvar itching
☐ midcycle bleeding
☐ post coital bleeding
☐ vulvar pain
☐ decreased libido
☐ vaginal itching
☐ pelvic pain
☐ vaginal dryness
☐ vaginal discharge
☐ vaginal odor

MUSCULOSKELETAL
☐ Negative
☐ Arthralgia (joint pain)
☐ joint swelling
☐ joint stiffness
☐ limb pain
☐ limb swelling

INTEGUMENTARY (SKIN)
☐ Negative
☐ Acne
☐ Breast discharge
☐ itching
☐ change in a mole
☐ breast pain
☐ breast lump

NEUROLOGICAL
☐ Negative
☐ Confused
☐ Memory problems
☐ dizziness
☐ headaches/migraines
☐ limb weakness
☐ difficulty walking

PSYCHIATRIC
☐ Negative
☐ Suicidal
☐ Sleep disturbances
☐ anxiety
☐ depression
☐ change in personality
☐ emotional problems

ENDOCRINE
☐ Negative
☐ Hair loss
☐ Hot flashes
☐ Heat/cold intolerance
☐ muscle weakness
☐ deepening of the voice
☐ feeling weak
☐ dry skin

HEMATOLOGY/IMMUNOLOGY
☐ Negative
☐ Easy bleeding
☐ seasonal allergies
☐ swollen glands
☐ easy bruising

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Acknowledgment Patient Was Provided
Notice of Privacy Practices

Patient Name: _____

MRN: _____

Date: _____

I acknowledge I was given MFA's Notice of Privacy Practices today.

_____
[Patient Signature]

Witnessed by:

_____
MFA Staff Member Name:
Title:

If patient declines to sign, MFA staff member signs below to confirm that Notice was offered to patient on the date listed above and patient declined to sign acknowledgment.

_____
MFA Staff Member Name:
Title:

Family History Questionnaire for Common Hereditary Cancer Syndromes

This is a screening tool for the common features of hereditary cancer syndromes. Based on the family history information you provide here, you MAY be appropriate for genetic testing and your provider may be able to change your medical management to improve your care.

Instructions: Please circle yes to those that apply to you and/or your family. Please consider these family members when completing the form:

Mother/Father/Sister/Brother/Children = **1st Degree Blood Relatives**
Aunt/Uncle/Grandparent/Niece/Nephew = **2nd Degree Blood Relatives**

			Specify Relative(s):	Age of Diagnosis:
Breast Cancer before age 50	Yes	No		
Ovarian Cancer at any age	Yes	No		
Breast Cancer in both breasts	Yes	No		
Both Breast AND Ovarian Cancer	Yes	No		
3 Breast Cancers on the same side of the family (at any age)	Yes	No		
Male Breast Cancer	Yes	No		
"Triple Negative" Breast Cancer under 60	Yes	No		
Family members who have tested positive for the BRCA gene	Yes	No		
Uterine Cancer before age 50	Yes	No		
Colorectal Cancer before age 50	Yes	No		
Both Uterine and Colorectal Cancer, one diagnosed < age 50	Yes	No		
3 or more of the following cancers on the same side of the family: Uterine, Colorectal, Ovarian, Stomach	Yes	No		
Ashkenazi Jewish Ancestry with breast and/or ovarian cancer In the family at any age?	Yes	No		

_____ Patient Signature

_____ Date

_____ Patient Name Printed

_____ Date of Birth

For Office Use Only

Patient is a candidate for genetic testing: Yes No

___ Genetic testing information provided
___ Genetic testing completed
___ Genetic testing Declined

_____ Provider Signature