

NAME: _____

DATE: _____

PRIMARY CARE DOCTOR _____

REFERRED BY: _____

DATE

Last period: Never ____/____/____

Would you accept a blood transfusion? Y N

Last pap smear: Never ____/____/____

Do you have Allergies to medicines? Y N

Last mammogram: Never ____/____/____

Yes: _____

Last colonoscopy: Never ____/____/____

Last bone density test: Never ____/____/____

OBSTETRICAL HISTORY:

of pregnancies: _____ # of children: _____ # of adopted children _____

Deliveries: # of vaginal _____ # of C-sections _____ # of miscarriages _____ # abortions _____ # ectopics _____

GYN HISTORY

YES NO

YES NO

Are your periods regular, once a month?

Have you ever been sexually active?

Do you have cramps with your periods?

Are you currently sexually active?

Any bleeding between your periods?

Are you in a single partner relationship?

Excessively heavy periods?

Any new partner in the past year?

Pain with intercourse?

If so, is partner male female

Do you have a history of: Fibroids

Duration together _____ months or _____ years

Ovarian Cysts

Current contraception? none condoms pills

Endometriosis

depo provera patch

Breast Disease

vaginal ring diaphragm IUD

Have you had HPV/Gardasil Vaccine

Implanon tubal ligation vasectomy

Please check if you have ever been treated for any of the following infections:

Vaginal bacterial infection/BV/Vaginosis

Trichomonas

Genital Warts

Gonorrhea

Chlamydia

Syphilis

Herpes

Have you **ever** had an abnormal pap smear?

When? _____ (w/in 3 years=HR)

Has it been more than 7 years since your last pap smear?

Did you begin sexual activity before you were 16 years old?

Have you had more than 5 sexual partners in your lifetime?

Have you ever been diagnosed with HIV?

Did your mother take the drug DES while pregnant with you?

MEDICAL PROBLEMS

YES NO

MEDICAL PROBLEMS

YES NO

High blood pressure

Anemia

Diabetes

Blood transfusions

High Cholesterol

Seizures/convulsions/epilepsy

Heart trouble/murmur

Bowel problems/IBS

type _____

Glaucoma

Stroke

Hepatitis/jaundice

Thyroid disease

Anxiety

type _____

Depression

Asthma/chronic lung disease

Osteoporosis/Osteopenia

Kidney infection/stones

Autoimmune disease type _____

Blood clots in veins/arteries

Cancer type _____

Seasonal Allergies

Other _____

Migraines

Heartburn

OPERATIONS

YES NO

DATE

YES NO

DATE

C-section

Tubal Ligation

Hysterectomy

Ovarian surgery

Laparoscopy

Bladder/Prolapse surgery

Hysteroscopy

Cone Biopsy/LEEP

Fibroid removal

Appendectomy

Uterine Ablation

Gall bladder removed

Fibroid Embolization

Breast biopsy/surgery

Other surgery/hospitalization: _____

FAMILY HISTORY	YES	NO	WHO?	YES	NO	WHO?
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>		High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Uterine cancer	<input type="checkbox"/>	<input type="checkbox"/>		Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>		Blood clot requiring blood thinners	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	before age 50?	Other: _____		
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	before age 50?			
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>				
SOCIAL HISTORY			YES	NO	YES	NO
Do you smoke?			<input type="checkbox"/>	<input type="checkbox"/>	Do you exercise regularly?	<input type="checkbox"/>
Do you drink alcohol at all? Avg. # drinks/day _____			<input type="checkbox"/>	<input type="checkbox"/>	Do you eat a diet high in fat/sugar?	<input type="checkbox"/>
Do you use any recreational drugs?			<input type="checkbox"/>	<input type="checkbox"/>	Do you wear a seat belt?	<input type="checkbox"/>
					Do you feel safe in your home/relationship?	<input type="checkbox"/> Yes <input type="checkbox"/> No

REVIEW OF SYSTEMS: Please check if any of the following apply:

CONSTITUTIONAL	Weight loss/gain <input type="checkbox"/>	MUSCULOSKELETAL	Muscle weakness <input type="checkbox"/>
	Headaches <input type="checkbox"/>		Muscle/ Joint Pain <input type="checkbox"/>
	Fever <input type="checkbox"/>		
	Fatigue <input type="checkbox"/>		
EYES	Spots before eyes <input type="checkbox"/>	SKIN/BREAST	Pain in breast <input type="checkbox"/>
	Vision changes <input type="checkbox"/>	Rash <input type="checkbox"/>	Lump in breast <input type="checkbox"/>
		Ulcers/sores <input type="checkbox"/>	Nipple discharge <input type="checkbox"/>
ENT/MOUTH	Ear problems <input type="checkbox"/>	NEUROLOGICAL	Dizziness <input type="checkbox"/>
	Ringing in ears <input type="checkbox"/>		Numbness in arms/legs <input type="checkbox"/>
	Sinus problems <input type="checkbox"/>		
CARDIOVASCULAR	Chest pain <input type="checkbox"/>	PSYCHIATRIC	Depression or anxiety <input type="checkbox"/>
	Heart racing/skipping beats <input type="checkbox"/>		
RESPIRATORY	Wheezing <input type="checkbox"/>	ENDOCRINE	Heat/cold intolerance <input type="checkbox"/>
	Shortness of breath <input type="checkbox"/>		Abnormal thirst <input type="checkbox"/>
			Hot flashes <input type="checkbox"/>
GASTROINTESTINAL	Diarrhea or constipation <input type="checkbox"/>	HEMATOLOGIC/ LYMPH	Frequent bruises <input type="checkbox"/>
	Blood in stool <input type="checkbox"/>		Cuts that do not stop bleeding <input type="checkbox"/>
	Nausea/vomiting <input type="checkbox"/>		Enlarged lymph nodes/glands <input type="checkbox"/>
GENITOURINARY	Pain with urination <input type="checkbox"/>	MEDICATIONS:	NONE <input type="checkbox"/>
	Frequency/urgency of urination <input type="checkbox"/>		
	Leaking urine <input type="checkbox"/>		
	Heavy periods <input type="checkbox"/>		
	Irregular periods <input type="checkbox"/>		
	Bleeding between periods <input type="checkbox"/>		
	Pelvic pain <input type="checkbox"/>		
	Pain with intercourse <input type="checkbox"/>		
	Vaginal itching/burning <input type="checkbox"/>		
	Abnormal discharge <input type="checkbox"/>		

PATIENT SIGNATURE: _____

DATE: _____

Please read the following 3 statements below and initial each one:

I understand that Atlanta GYN & OB, PC does not bill patients for office visits or copays. Payment must be made at the time of the visit.

Initials: _____

I understand that I will be charged a cancellation fee for canceling my appointment less than 24 hours in advance. Failure to show up for an appointment will result in a No Show Fee which must be paid prior to my next appointment.

Initials: _____

I have been given a copy of Atlanta GYN & OB, PC's Notice of Privacy Practices to read. (If you have not received our Privacy Practices Notice, please see Receptionist to receive your copy)

Initials: _____