

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

PRIMARY CARE DOCTOR \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

<u>DATE</u>			
Last period:	<input type="checkbox"/> Never	____/____/____	Would you accept a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No
Last pap smear:	<input type="checkbox"/> Never	____/____/____	Do you have any allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No
Last mammogram:	<input type="checkbox"/> Never	____/____/____	Yes: _____
Last colonoscopy:	<input type="checkbox"/> Never	____/____/____	<b>REASON FOR VISIT:</b> <input type="checkbox"/> Annual Exam and/or
Last bone density:	<input type="checkbox"/> Never	____/____/____	<input type="checkbox"/> Problem: _____

**OBSTETRICAL HISTORY:**

# of pregnancies: \_\_\_\_\_ # of children: \_\_\_\_\_ # of adopted children \_\_\_\_\_

Deliveries: # of vaginal \_\_\_\_\_ # of C-sections \_\_\_\_\_ # of miscarriages \_\_\_\_\_ # abortions \_\_\_\_\_ # ectopics \_\_\_\_\_

<b>GYN HISTORY</b>	YES	NO		YES	NO
Are your periods regular, once a month?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been sexually active?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have cramps with your periods?	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently sexually active?	<input type="checkbox"/>	<input type="checkbox"/>
Any bleeding between your periods?	<input type="checkbox"/>	<input type="checkbox"/>	Is your partner <input type="checkbox"/> male? <input type="checkbox"/> female?		
Excessively heavy periods?	<input type="checkbox"/>	<input type="checkbox"/>	Any new sexual partner in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
Pain with intercourse?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had more than one sexual partner		
Do you have a history of: Fibroids?	<input type="checkbox"/>	<input type="checkbox"/>	in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian Cysts?	<input type="checkbox"/>	<input type="checkbox"/>	Current contraception? <input type="checkbox"/> none <input type="checkbox"/> condoms		
Endometriosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> pills <input type="checkbox"/> depo provera <input type="checkbox"/> patch		
Breast Disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> vaginal ring <input type="checkbox"/> diaphragm <input type="checkbox"/> IUD		
Have you had the HPV Vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Implanon <input type="checkbox"/> tubal ligation <input type="checkbox"/> vasectomy		
(Gardasil or Cervarix)					

<i>Please check if you have ever been treated for any of the following infections:</i>		<b>YES</b>	<b>NO</b>
Vaginal bacterial infection/BV/Vaginosis	<input type="checkbox"/>		
Trichomonas	<input type="checkbox"/>		
Genital Warts	<input type="checkbox"/>		
Gonorrhea	<input type="checkbox"/>		
Chlamydia	<input type="checkbox"/>		
Syphilis	<input type="checkbox"/>		
Herpes	<input type="checkbox"/>		
	Have you <b>ever</b> had an abnormal pap smear?	<input type="checkbox"/>	<input type="checkbox"/>
	When? _____ (w/in 3 years=HR)		
	Has it been more than 7 years since your last pap smear?	<input type="checkbox"/>	<input type="checkbox"/>
	Did you begin sexual activity before you were 16 years old?	<input type="checkbox"/>	<input type="checkbox"/>
	Have you had more than 5 sexual partners in your lifetime?	<input type="checkbox"/>	<input type="checkbox"/>
	Have you ever been diagnosed with HIV?	<input type="checkbox"/>	<input type="checkbox"/>
	Did your mother take the drug DES while pregnant with you?	<input type="checkbox"/>	<input type="checkbox"/>

<b>MEDICAL PROBLEMS</b>	YES	NO	<b>MEDICAL PROBLEMS</b>	YES	NO
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/convulsions/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble/murmur	<input type="checkbox"/>	<input type="checkbox"/>	Bowel problems/IBS	<input type="checkbox"/>	<input type="checkbox"/>
type: _____			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
type: _____			Depression	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/chronic lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis/Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>
Kidney infection/stones	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots in veins/arteries	<input type="checkbox"/>	<input type="checkbox"/>	type: _____		
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	type: _____		
			Other _____		

<b>OPERATIONS</b>	YES	NO	DATE	<b>OPERATIONS</b>	YES	NO	DATE
C-section	<input type="checkbox"/>	<input type="checkbox"/>		Tubal Ligation	<input type="checkbox"/>	<input type="checkbox"/>	
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>		Ovarian surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Laparoscopy	<input type="checkbox"/>	<input type="checkbox"/>		Bladder/Prolapse surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Hysteroscopy	<input type="checkbox"/>	<input type="checkbox"/>		Cone Biopsy/LEEP	<input type="checkbox"/>	<input type="checkbox"/>	
Uterine Fibroid removal	<input type="checkbox"/>	<input type="checkbox"/>		Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Uterine Ablation	<input type="checkbox"/>	<input type="checkbox"/>		Gall bladder removed	<input type="checkbox"/>	<input type="checkbox"/>	
Fibroid Embolization	<input type="checkbox"/>	<input type="checkbox"/>		Breast biopsy/surgery	<input type="checkbox"/>	<input type="checkbox"/>	
				Other surgery/hospitalization: -----			

<b>FAMILY HISTORY</b>	<b>YES</b>	<b>NO</b>	<b>WHO?</b>	<b>YES</b>	<b>NO</b>	<b>WHO?</b>
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"/>				
<b>SOCIAL HISTORY</b>	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>	
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>		Do you exercise regularly?	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Do you use any recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>		Do you wear a seat belt?	<input type="checkbox"/>	<input type="checkbox"/>
				Do you feel safe in your home/relationship?	<input type="checkbox"/>	<input type="checkbox"/>

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

<b>CONSTITUTIONAL</b>	Weight loss <input type="checkbox"/>	<b>MUSCULOSKELETAL</b>	Muscle weakness <input type="checkbox"/>
	Weight gain <input type="checkbox"/>		Muscle/joint pain <input type="checkbox"/>
	Headaches <input type="checkbox"/>		
	Fever <input type="checkbox"/>		
	Fatigue <input type="checkbox"/>		
<b>EYES</b>	Spots before eyes <input type="checkbox"/>	<b>SKIN/BREAST</b>	Pain in breast <input type="checkbox"/>
	Vision changes <input type="checkbox"/>		Lump in breast <input type="checkbox"/>
			Nipple discharge <input type="checkbox"/>
			Skin changes <input type="checkbox"/>
<b>ENT/MOUTH</b>	Ear problems <input type="checkbox"/>	<b>NEUROLOGICAL</b>	Dizziness <input type="checkbox"/>
	Ringing in ears <input type="checkbox"/>		Numbness in arms/legs <input type="checkbox"/>
	Sinus problems <input type="checkbox"/>		
<b>CARDIOVASCULAR</b>	Chest pain <input type="checkbox"/>	<b>PSYCHIATRIC</b>	Depression or anxiety <input type="checkbox"/>
	Heart racing/skipping beats <input type="checkbox"/>		
<b>RESPIRATORY</b>	Wheezing <input type="checkbox"/>	<b>ENDOCRINE</b>	Heat/cold intolerance <input type="checkbox"/>
	Shortness of breath <input type="checkbox"/>		Abnormal thirst <input type="checkbox"/>
			Hot flashes <input type="checkbox"/>
<b>GASTROINTESTINAL</b>	Diarrhea or constipation <input type="checkbox"/>	<b>HEMATOLOGIC/ LYMPH</b>	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"/>
<b>GENITOURINARY</b>	Pain with urination <input type="checkbox"/>	<b>MEDICATIONS:</b>	<b>NONE</b> <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 keep 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:** \_\_\_\_\_