

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

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

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

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

REASON FOR VISIT:  Annual Exam and/or  Problem: \_\_\_\_\_

Last period:	<input type="checkbox"/> Never	DATE _____/_____/_____	Any new medical problems or surgeries since your last visit here?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Last pap smear:	<input type="checkbox"/> Never	_____/_____/_____	Yes: _____	
Last mammogram:	<input type="checkbox"/> Never	_____/_____/_____	Any new family history since your last visit here?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Last colonoscopy:	<input type="checkbox"/> Never	_____/_____/_____	Yes: _____	
Last bone density test:	<input type="checkbox"/> Never	_____/_____/_____	Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any allergies to medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Do you drink alcohol at all?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Yes: _____			Avg. # drinks per day _____	
Any changes in medications since last visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Do you use recreational drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Yes: _____				

**OBSTETRICAL HISTORY:**

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

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

IN THE PAST YEAR	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 in the past year?	<input type="checkbox"/> <input type="checkbox"/>
Pain with urination?	<input type="checkbox"/>	<input type="checkbox"/>	Current contraception? <input type="checkbox"/> none <input type="checkbox"/> condoms	
Frequency/urgency of urination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> pills <input type="checkbox"/> depo provera <input type="checkbox"/> patch	
Leaking urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> vaginal ring <input type="checkbox"/> diaphragm <input type="checkbox"/> IUD	
Pelvic pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Implanon <input type="checkbox"/> tubal ligation <input type="checkbox"/> vasectomy	
Vaginal itching/burning?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had the HPV/Gardasil Vaccine?	<input type="checkbox"/> <input type="checkbox"/>
Any abnormal discharge?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a history of: Fibroids?	<input type="checkbox"/> <input type="checkbox"/>
Any hot flashes or night sweats?	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian Cysts?	<input type="checkbox"/> <input type="checkbox"/>
Any vaginal dryness?	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis?	<input type="checkbox"/> <input type="checkbox"/>
Any breast problems?	<input type="checkbox"/>	<input type="checkbox"/>	Breast Disease?	<input type="checkbox"/> <input type="checkbox"/>

Please check if you have ever been treated for any of the following infections: 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 ever had an <b>abnormal</b> pap smear? When? _____	YES	NO
	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"/>

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:** \_\_\_\_\_