Name:_____ Date:_____

Name of your PCP:_____ Referred by: _____

Reason for visit: ☐ Annual ☐ Problem _____

Allergies to medications ☐ Yes ☐ No If Yes, to what medicine? _____

Present Medications: _____

Would you like Screening for Sexually Transmitted Diseases Today? ☐ Yes ☐ No

Would you accept a Blood Transfusion in life saving circumstances? ☐ Yes ☐ No

Have you had the following Immunizations? ☐ HPV ☐ Rubella ☐ Hepatitis B ☐ Flu (this year?) ☐ Tetanus/Pertussis (TDap) when_____

Last Period: ___/___/___ ☐ Never # of Pregnancies ____ # of Children ____ # of adopted children____

Last Pap Smear: ___/___/___ ☐ Never # of Vaginal deliveries ____ # of C-section deliveries ____

Last Mammogram: ___/___/___ ☐ Never # of miscarriages ____ # of Abortions ____ # of Ectopics ____

Last Colonoscopy: ___/___/___ ☐ Never

Last Bone Density: ___/___/___ ☐ Never

GYN History

Are your periods regular, once a month? ☐ Yes ☐ No

Do you have excessive cramping with your periods? ☐ Yes ☐ No

Do you have bleeding in between your periods? ☐ Yes ☐ No

Do you have excessively heavy periods? ☐ Yes ☐ No

Do you want to do something about your heavy periods? ☐ Yes ☐ No

Do you have pain with intercourse? ☐ Yes ☐ No

Do you have leakage of urine? ☐ Yes ☐ No

Do you have an over active bladder? ☐ Yes ☐ No

Do you have a history of:

Fibroids? ☐ Yes ☐ No Ovarian Cysts? ☐ Yes ☐ No

Endometriosis? ☐ Yes ☐ No Breast Disease? ☐ Yes ☐ No

Have you ever been sexually active? ☐ Yes ☐ No

Are you currently sexually active? ☐ Yes ☐ No

New sexual partner in the last year? ☐ Yes ☐ No

More than one partner in the last year? ☐ Yes ☐ No

How long have you been with your current partner? _____

Is your sexual partner ☐ Male or ☐ Female

Current contraception: ☐ None ☐ Condoms

☐ Pills ☐ Patch ☐ Vaginal Ring ☐ IUD

☐ Depo-provera ☐ Implanon ☐ Diaphragm

☐ Tubal Ligation ☐ Vasectomy

Are Finished having children? ☐ Yes ☐ No

Have you been treated for:

Bacterial Vaginal infection/ BV ☐ Yes ☐ No

Trichomonas ☐ Yes ☐ No

Genital Warts (HPV) ☐ Yes ☐ No

Gonorrhea ☐ Yes ☐ No

Chlamydia ☐ Yes ☐ No

Syphilis ☐ Yes ☐ No

Herpes ☐ Yes ☐ No

Have you ever had an abnormal Pap Smear? ☐ Yes ☐ No

If Yes, when _____ What treatment did you have?_____

Has it been more than 7 years since your last pap? ☐ Yes ☐ No

Did you begin sexual activity before age 16 yrs. old? ☐ Yes ☐ No

Have you had more than 5 lifetime partners? ☐ Yes ☐ No

Have you ever been diagnosed with HIV? ☐ Yes ☐ No

Did your mother take DES while pregnant with you? ☐ Yes ☐ No

Your Medical History:

Hypertension ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

High Cholesterol ☐ Yes ☐ No

Heart Trouble ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Thyroid Problems ☐ Yes ☐ No Type:_____

Asthma ☐ Yes ☐ No

Kidney Stones ☐ Yes ☐ No

Blood Clots/DVT ☐ Yes ☐ No

Migraines ☐ Yes ☐ No

Heartburn ☐ Yes ☐ No

Anemia ☐ Yes ☐ No

Seizures/Epilepsy ☐ Yes ☐ No

Bowel Problems ☐ Yes ☐ No

Glaucoma ☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No

Anxiety ☐ Yes ☐ No

Depression ☐ Yes ☐ No

Osteoporosis ☐ Yes ☐ No

Osteopenia ☐ Yes ☐ No

Autoimmune Disease ☐ Yes ☐ No

Type:_____

Cancer ☐ Yes ☐ No

Type:_____

Other Medical Problems:

_____

Surgeries:

	What Year		What Year		What Year		
C-Section	☐ _____	Uterine Fibroid Removal	☐ _____	Tubal Ligation	☐ _____	Gallbladder	☐
Hysterectomy	☐ _____	Uterine Ablation	☐ _____	Bladder/Prolapse	☐ _____	Breast: biopsy	☐
Laparoscopy	☐ _____	Fibroid Embolization (UFE)	☐ _____	LEEP/ Cone	☐ _____	reduction	☐
Hysteroscopy	☐ _____	Ovarian Surgery	☐ _____	Appendectomy	☐ _____	augmentation	☐

Other Surgeries:_____

Family History:

		Who			Who
Breast Cancer	☐	_____	Diabetes	☐	_____
Ovarian Cancer	☐	_____	Hypertension	☐	_____
Uterine Cancer	☐	_____	Osteoporosis	☐	_____
Colon Cancer	☐	_____ ☐ before age 50			
Heart Attack	☐	_____ ☐ before age 50	Blood Clots/DVT	☐	_____
Stroke	☐	_____ ☐ before age 50	Other	☐	_____
High Cholesterol	☐	_____	NONE	☐	

Social History:

Do you Smoke?	☐ Yes	☐ No	Do you exercise regularly?	☐ Yes	☐ No
Do you drink Alcohol?	☐ Yes	☐ No	Do you eat a diet high in Fat/Sugar?	☐ Yes	☐ No
Avg. # drinks per day?_____ #per week_____			Do you wear a seat belt?	☐ Yes	☐ No
Do you use recreational drugs?	☐ Yes	☐ No	Do you feel safe in your home/relationship?	☐ Yes	☐ No

Review of Systems:

	Now	Past Year
General:		
Weight Loss	☐	☐
Weight Gain	☐	☐
Headaches	☐	☐
Fever	☐	☐
Fatigue	☐	☐
ENT:		
Vision Changes	☐	☐
Spots before eyes	☐	☐
Sinus Problems	☐	☐
Ear problems	☐	☐
Ringing in ears	☐	☐
Hearing Loss	☐	☐
Cardiovascular:		
Chest pain	☐	☐
Heart racing/skips beats	☐	☐
Respiratory:		
Wheezing	☐	☐
Shortness of breath	☐	☐
Gastrointestinal:		
Diarrhea/Constipation	☐	☐
Nausea/Vomiting	☐	☐
Blood in Stool	☐	☐
Genitourinary:		
Leaking of urination	☐	☐
Frequency/Urgency	☐	☐
Over Active Bladder	☐	☐
Pain with urination	☐	☐
Pelvic Pain	☐	☐
Vaginal itching or Burning	☐	☐
Abnormal discharge	☐	☐

	Now	Past Year
Musculoskeletal:		
Muscle weakness	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
Breast:		
Pain in breast(s)	☐	☐
Lump in breast(s)	☐	☐
Nipple discharge	☐	☐
Changes to breast skin	☐	☐
Neurological:		
Dizziness	☐	☐
Numbness in arms/legs	☐	☐
Psychiatric:		
Depression	☐	☐
Anxiety	☐	☐
Endocrine:		
Heat/Cold Intolerance	☐	☐
Abnormal thirst	☐	☐
Hot Flashes	☐	☐
Hematologic/Lymphatic		
Frequent/Easy bruising	☐	☐
Cuts that do not stop bleeding	☐	☐

Patient Signature _____ Date: _____

Please read the following 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 an appointment less than 24 hours in advance. Initials _____

Failure to keep an appointment will result in a "No Show" fee which must be paid prior to your next visit. Initials _____

I have been given a copy of Atlanta GYN & OB, PC's Notice of Privacy Practices to read. (If you have not received this Privacy notice, please see our receptionist for your copy) Initials _____