

OBSTETRICS & GYNECOLOGY OF ATLANTA, P.C.

NAME: _____ DATE: ___/___/___ BIRTHDATE: ___/___/___

REFERRED BY: _____ DATE OF LAST PERIOD: ___/___/___ AGE: _____

REASON FOR VISIT: ROUTINE PHYSICAL PROBLEM DESCRIBE PROBLEM: _____

CHECK IF YOU HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST:

MAJOR ILLNESSES	YES	NO	MAJOR ILLNESSES	YES	NO
Abnormal Pap Smear			Hepatitis / Liver disease		
Anxiety			High Blood Pressure		
Arthritis			High Cholesterol		
Asthma			Kidney Infections (not bladder or UTI)		
Blood transfusions			Kidney Stones		
Bowel Disorder			Migraine Headaches		
Breast Cancer			Osteoporosis / Osteopenia		
Cancer (what type?)			Rheumatic Fever		
Chronic Lung Disease			Seizure Disorder		
Deep vein thrombosis / Pulmonary embolism			Sexually Transmitted Disease (what type?)		
Depression			Stroke		
Diabetes			Tuberculosis - TB		
Glaucoma			Thyroid Disease		
Heart Disease			Ulcers		
			OTHER:		

WHEN WAS YOUR LAST TEST OR IMMUNIZATION?

	DATE		DATE
Last PAP Smear		Tetanus	
Mammogram		Flu Shot	
Colonoscopy / Sigmoidoscopy		TB Skin Test	
Bone Density		OTHER:	

PLEASE LIST ANY PAST INJURIES OR ILLNESSES:

TYPE	DATE	TYPE	DATE

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:

SURGERY/REASON	DATE	SURGERY/REASON	DATE

NAME: _____ BIRTHDATE: _____ / _____ / _____

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:					
DRUG NAME	DOSAGE	PHYSICAN	DRUG NAME	DOSAGE	PHYSICAN

ALLERGIES TO MEDICATIONS / SUBSTANCES (LATEX GLOVES, ETC.?)	List:
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CIRCLE AND CHECK IF YOUR BLOOD RELATIVES HAVE HAD:

MAJOR ILLNESSES	YES	NO	WHAT BLOOD RELATIVE? Mother, Father, etc.
Alzheimer's Disease			
Arthritis			
Bowel Disease (what type?)			
Breast Cancer			
Cancer (what type?)			
Colon polyps			
Chronic Lung Disease			
Deep vein thrombosis / Pulmonary embolism			
Depression / Mental illness / Suicide			
Diabetes			
Glaucoma			
Heart Disease			
Hepatitis / Liver disease			
High Blood Pressure			
High Cholesterol			
Osteoporosis			
Stroke			
Thyroid Disease			
OTHER:			

YOUR GYN HISTORY

Do you use birth control?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Condoms	<input type="checkbox"/> Nuvaring
<input type="checkbox"/> Depo Provera	<input type="checkbox"/> Birth Control Patch
<input type="checkbox"/> Diaphragm	<input type="checkbox"/> None
<input type="checkbox"/> IUD - Kind	<input type="checkbox"/> Natural Family Plan / Rhythm
- Date Inserted:	<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> Birth Control Pill	<input type="checkbox"/> Vasectomy
- Name:	<input type="checkbox"/> Withdrawal
<input type="checkbox"/> Contraceptive Foam / Jelly	<input type="checkbox"/> Other:

What age did you have your first period: _____	
How many days are there from start of period to start of next period _____ days	
How long does your period last? _____ days	Flow: <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy
Do you have clots? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have bleeding between periods? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have cramps? <input type="checkbox"/> No <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe	Do you have pelvic pain at other times? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you gone thru Menopause <input type="checkbox"/> Yes <input type="checkbox"/> No	At what age: _____

NAME: _____ BIRTHDATE: _____ / _____ / _____

YOUR OB HISTORY

	NUMBER		NUMBER
Total # of pregnancies		Full term births	
Premature		Abortions Induced	
Miscarriages		Living children	

On the chart below, please fill in answers for each pregnancy, including abortions or miscarriages.

No.	Birth Date	Wks Gest	Labor (hrs)	Baby's Weight Sex	Del Type Vag/CSection	Anes	Early Labor?	Wt Gain	Comments / Complications	Location
1				M						
				F						
2				M						
				F						
3				M						
				F						
4				M						
				F						
5				M						
				F						
6				M						
				F						

SOCIAL HISTORY

PLEASE LIST HABITS	
Do you use Seat Belt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you do a Self Breast Exam	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you Drink Milk	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glasses per day:	
Do you eat cheese or other dairy products	<input type="checkbox"/> Yes <input type="checkbox"/> No
Servings per day:	
Do you Take Calcium	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name and Dosage:	
Do you Exercise	<input type="checkbox"/> None <input type="checkbox"/> Less than 3 times per week <input type="checkbox"/> More than 3 times per week
Are you Sexually Active	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have sex with?	<input type="checkbox"/> Husband <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both
New sexual partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No How long? _____ First Intercourse at Age: _____
Lifetime sexual partners	<input type="checkbox"/> Husband <input type="checkbox"/> Less than 5 <input type="checkbox"/> More than 5
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Engaged
Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Packs per day: _____	Number of Years: _____
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drinks per day: _____	Drinks per week: _____
Drug User	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kind: _____	Frequency: _____
History of abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Physical <input type="checkbox"/> Emotional <input type="checkbox"/> Sexual	
List all Natural or Herbal remedies, over the counter drugs, vitamins or minerals you are taking	List: _____
Occupation:	
Race	<input type="checkbox"/> White <input type="checkbox"/> African/American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other _____

NAME: _____ BIRTHDATE: _____ / _____ / _____

REVIEW OF SYSTEMS:
PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLIES TO YOU NOW.

CONSTITUTIONAL	NOTES	GENITOURINARY (CONT)	NOTES
Weight Loss <input type="checkbox"/>		Decreased sex drive <input type="checkbox"/>	
Weight Gain <input type="checkbox"/>		Painful intercourse <input type="checkbox"/>	
Fever <input type="checkbox"/>		Possible Pregnancy <input type="checkbox"/>	
Fatigue <input type="checkbox"/>		Genital Sores <input type="checkbox"/>	
Night Sweats <input type="checkbox"/>		Vaginal discharge <input type="checkbox"/>	
Hot Flashes <input type="checkbox"/>			
EYES		SKIN	
Double vision <input type="checkbox"/>		Rashes <input type="checkbox"/>	
Vision changes <input type="checkbox"/>		Itching <input type="checkbox"/>	
HENT		Skin Dryness <input type="checkbox"/>	
Headaches <input type="checkbox"/>		Skin Lesions <input type="checkbox"/>	
Dizziness <input type="checkbox"/>		Changes to Lesions or Moles <input type="checkbox"/>	
Sore Throat <input type="checkbox"/>		Acne <input type="checkbox"/>	
Sinus Pain <input type="checkbox"/>			
Nose Bleeding <input type="checkbox"/>		NEUROLOGICAL	
Thyroid Mass <input type="checkbox"/>		Muscular Weakness <input type="checkbox"/>	
Neck Pain <input type="checkbox"/>		Numbness or Tingling <input type="checkbox"/>	
BREAST		Difficulty Concentrating <input type="checkbox"/>	
Lumps <input type="checkbox"/>		Memory Difficulties <input type="checkbox"/>	
Tenderness <input type="checkbox"/>		Speech Difficulties <input type="checkbox"/>	
Swelling <input type="checkbox"/>		Seizures <input type="checkbox"/>	
Discharge <input type="checkbox"/>		Loss of Balance <input type="checkbox"/>	
Pain in Breast <input type="checkbox"/>			
Abn Changes in Breast <input type="checkbox"/>		MUSCULOSKELETAL	
CARDIOVASCULAR		Joint Pain or Swelling <input type="checkbox"/>	
Chest Pain <input type="checkbox"/>		Muscle Pain <input type="checkbox"/>	
Irregular Heart Beats <input type="checkbox"/>		Back Pain <input type="checkbox"/>	
Rapid Heart Rate <input type="checkbox"/>			
Fainting <input type="checkbox"/>		ENDOCRINE	
Swelling of legs <input type="checkbox"/>		Loss of Hair <input type="checkbox"/>	
Varicose veins <input type="checkbox"/>		Difficulty Tolerating Cold <input type="checkbox"/>	
RESPIRATORY		Difficulty Tolerating Heat <input type="checkbox"/>	
Wheezing <input type="checkbox"/>			
Cough <input type="checkbox"/>		PSYCHIATRIC	
Shortness of breath <input type="checkbox"/>		Anxiety <input type="checkbox"/>	
Spitting up blood <input type="checkbox"/>		Depression <input type="checkbox"/>	
GASTROINTESTINAL		Impulsive Behavior <input type="checkbox"/>	
Nausea <input type="checkbox"/>		Suicidal Thoughts <input type="checkbox"/>	
Vomiting <input type="checkbox"/>		Excessive Anger <input type="checkbox"/>	
Diarrhea <input type="checkbox"/>		Mood Swings <input type="checkbox"/>	
Constipation <input type="checkbox"/>		Emotional Abuse <input type="checkbox"/>	
Abdominal Pain <input type="checkbox"/>		Physical Abuse <input type="checkbox"/>	
Bloody / Black Stool <input type="checkbox"/>		Sexual Abuse <input type="checkbox"/>	
Hemorrhoids <input type="checkbox"/>			
Jaundice <input type="checkbox"/>		HEMATOLOGIC /	
GENITOURINARY		LYMPHATIC	
Urgency of urination <input type="checkbox"/>		Bruises, frequent or easily <input type="checkbox"/>	
Frequency of urination <input type="checkbox"/>		Cuts do not stop bleeding <input type="checkbox"/>	
Pain with urination <input type="checkbox"/>		Enlarged lymph nodes <input type="checkbox"/>	
Nighttime urination <input type="checkbox"/>			
Losing urine <input type="checkbox"/>		ALLERGIC / IMMUNOLOGIC	
Blood in urine <input type="checkbox"/>		Frequent illness <input type="checkbox"/>	
		Seasonal Allergies <input type="checkbox"/>	
		OTHER	
		1 <input type="checkbox"/>	
		2 <input type="checkbox"/>	
		3 <input type="checkbox"/>	