

OBSTETRICS & GYNECOLOGY OF ATLANTA, P.C.

PROBLEM/ANNUAL RETURN VISIT

Patient Name _____ Account # _____

Date _____ Birthdate _____ Patient Age _____

BP ____/____ Weight _____ Height _____

Nursing Notes _____

Mammo today _____ Ultrasound today _____ Bone Density today _____

Patient Only (If you are here for an annual - Please fill out the back of this form)

Reason for today's visit _____

Date last period began _____ Allergies _____

How many times have you been pregnant? _____ How many children do you have? _____

What do you do to avoid pregnancy? Please circle:

Birth Control Pills (brand) _____	IUD _____	Tubal Ligation _____
Vasectomy _____	Condoms _____	Rhythm Method _____
None _____	Nuva Ring _____	Orth Evra Patches _____

Current Medications (please include dosages) _____

Date of Last Mammogram _____ Date of Last Colonoscopy _____

Date of Last Bone Density Test _____

Do you have a family history of breast, ovarian, or colon cancer (supply details) ? _____

Have you had an abnormal pap in the last 5 years? _____ What type of treatment or follow up did you have for this? _____

Please describe any changes in personal, social, or health status since your last visit here

FILL OUT FOR ANNUALS ONLY

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