2905 Jordan Ct, Suite G, Alpharetta, GA 30005 P: (678)335-9223 F: (678)335-9236

Date______________________

Patient Information

Last Name ______________________________ First ______________________ Middle_____________

Maiden Name______________________ Date of Birth ________________ Age_______ Marital Status___________

Reason for Today's Visit (Circle) Annual Exam Postoperative Visit Pregnancy Confirmation OB

Gynecologic Problem (explain) ____

Do you have any new medical concerns today? □ No □ Yes ____

Date of Last Pap __________________________ **Are you currently Pregnant?** ___________________________

Have you ever had an abnormal pap? □ No □ Yes If Yes, when? ____________________________________

1st day of your Last Period _________________________________ **Was it normal?** ____________________

Birth Control Method (circle) None Vasectomy Condom IUD Tubal Ligation/Essure Diaphragm

Birth Control Pill/Patch/Ring (name) _________________________________ Other ____________________

Medications Please list all current medications and dosages as accurately as possible (including over-the-counter drugs)

MEDICATION DOSAGE APPROX. DATE PRESCRIBED

____

____

____

____

____

Medication Allergies _______ None

Please list all medication allergies or check if none ________ Are you allergic to Latex?

____

____

PLEASE DO NOT WRITE BELOW THIS LINE

Para ___________ BP_____________ Weight ______________ U/A__________________ UCG_______________

Pap ____________HR HPV _____________ Wet Prep_____________ KOH_____________ Guaiac_______________

Cultures/Other: Yeast Genprobes Urine Culture

Blood Tests: ____

Notes____

Changes in Medical/Surgical History____

ALPHA OB GYN

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Name___________________________________ **Date**_____________________

Medical History

Menstrual Cycle History

Age at 1st period ____________ # of days between periods ______________ Length of Period ______________ days

Do you have: _______Excessive Bleeding ______ Pain/Cramps ______ Mood Swings ______ Bleeding Between Periods

GYN History ***If yes, please provide date and brief explanation***

Have you ever had an abnormal pap semar? No Yes____

Do you have problems with vaginal discharge? No Yes____

Do you have any urinary problems or leakage? No Yes____

Do you have any breast problems? No Yes____

Have you had a MAMMOGRAM? No N/A Yes(date of most recent)_____________________________

Have you had a BONE DENSITY SCAN? No N/A Yes(date of most recent)_____________________________

Have you had a COLONOSCOPY? No N/A Yes(date of most recent)_____________________________

Have you received the HPV Vaccine? No N/A Yes(date of most recent)_____________________________

Please check if you have or have had any of the following:

____Fibroids ____Ovarian Cysts ____Endometriosis ____Pelvic Adhesions/Pain

____Herpes ____Chlamydia/Gonorrhea ____Condyloma (warts) ____HPV

____HIV/AIDS ____PMS ____Other____

Pregnancy History # of pregnancies______ # of full term births______ # of elective terminations______

# of living children______ # of premature births______ # of miscarriages______

Date Born	Sex	Birth Weight	# weeks Pregnant	Hours in Labor	Type of Delivery	Pain Meds	Complications

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Name__________________________________ **Date**____________________

Medical History continued

Personal Medical History *(Please check all that apply)*

_____No known Problems _____Breast Problems _____Heart Disease _____Lupus/Autoimmune Disorder

____Alcohol/Drug Abuse ____Cancer (explain) ____Hepatitis ____Mitral Valve Prolapse

____Asthma ___________________ ____High Blood Pressure ____Physical Abuse

____Birth Defects ____________________ ____High Cholesterol ____Seizure Disorder

____Blood Clots ____Depression/Anxiety ____Hypothyroidism ____Stroke

____Blood Disorder/Anemia ____Diabetes ____Kidney/Bladder Problems ____Thyroid Problems

____Other Medical Problems (list)____

Surgical Medical History

Month/Year	**Type of Surgery**	**Complications(if yes, explain)**

Family Medical History *(please check all that apply)*

____No Known Problems

Has anyone in your immediate family had

____Alcohol/Drug Abuse ____Cancer(explain) ____Diabetes ____High Blood Pressure

____Birth Defects ___________________ ____Endometriosis ____High Cholesterol

____Blood Disorder/Anemia ___________________ ____Heart Disease ____Stroke

____Other Medical Problems (list)____

Social History

What is your occupation? ____

Do you smoke? □ No □Yes # packs per day ____ □Former When did you quit?_______ How long did you smoke?_______

Do you drink alcohol? □ No □ Yes _______ # per _________ (day/week/month)

Do you exercise? □ No □ Yes Type___________________________________ Hours per week _________________________

Do you use street drugs? □ No □ Yes How often? ___________________

Are you sexually active? □ No □ Yes Do you have one partner ___________ or many partners_________?

I certify the preceding information is correct to the best of my knowledge.

Signature____ Date _________________________