Women's Specialists OF NORTHSIDE GWINNETT

NAME_____ **DOB** _____ **AGE** _____ **DATE** _____

Which provider are you seeing? _____ Appointment Date: _____

Are you new to this practice? Yes ___ No ___

Race: African American/Black ____ , American Indian/ Alaskan Native ____ , Asian ____ , Caucasian/White ____ , Pacific Islander/Native Hawaiian ____ , Other ____ , Declined ____
Ethnicity: Hispanic or Latino ____ Not Hispanic or Latino ____

Reason for today's visit:_____

Local Pharmacy Name: _____ **Pharmacy phone:** _____

Mail Order Pharmacy:_____ **Phone:** _____

ALLERGIES:

Drug:_____ **Food:**_____
Latex Allergy: Yes ___ No ___

Physician who referred you: _____
Primary Care Provider: _____
Other Care providers: (please specify specialty) _____

OBSTETRICAL HISTORY:

Total Pregnancies		Full Term Births		Premature Births	
Abortions Ectopic		Miscarriages		Pregnancies	

	First Name	Date of Birth	Birth Weight	M/F	Doctor's Name	Delivery Method	Complications
1							
2							
3							
4							
5							
6							
7							

SURGICAL HISTORY / SERIOUS ACCIDENTS/ HOSPITALIZATIONS: * If NONE, please check

Date	Operation or Illness	Doctor	Hospital	Complications

FAMILY HISTORY: List any 1st Degree relatives (mother, father, grandparents, siblings, and children) who have had any of the following:

Unknown/ Adopted _____

				Cancers:	
Endometriosis	_____	Stroke	_____	Breast	_____
Uterine fibroids	_____	Diabetes	_____	Ovarian	_____
Heart attack	_____	Osteoporosis	_____	Colon	_____
High blood pressure	_____			Melanoma	_____
Blood Clots	_____	Other	_____	Other	_____

PATIENT INFORMATION FORM

SOCIAL HISTORY:

School completed: High School ____ 2 YR College ____
4 YR College ____ Grad School ____

Occupation:_____

Exercise weekly? 0 - 1 ____ 2-3 ____ more than 4 _____

Use of alcohol? Never ____ Rarely ____ Moderate _____
Daily _____ Two or more times in the past 12 months
had four or more alcoholic beverages in one day? _____

Use of recreational drugs? Never ____ Previous ____ Current ____
Drug used _____
Use of tobacco? Never ____ Previous ____ Current ____
(# per/day ____ # Yrs ____)
Vaping? Never ____ Previous ____ Current ____
(# per/day ____ # Yrs ____)
Physical ____ Emotional ____ Sexual ____
Have you ever been a victim of Sexual/Physical/Emotional abuse?
Yes ____ No ____
Please Specify:_____

MEDICAL HISTORY (Have you been diagnosed with an of the following illnesses? If so note YEAR of diagnosis):

Illness:	Yes	No	Date
GYNECOLOGICAL:			
STD/STI;	( )	( )	_____
If YES, please circle: *Chlamydia, herpes, genital warts Gonorrhea, syphilis, trichomonas*			
Vaginal Infections:	( )	( )	_____
If YES, please circle: *bacterial infection, yeast infection*			
Endometriosis	( )	( )	_____
Uterine Fibroids	( )	( )	_____
CARDIOVASCULAR:			
Heart Murmur	( )	( )	_____
Heart Attack	( )	( )	_____
Heart Defect	( )	( )	_____
Heart Palpitations	( )	( )	_____
High Blood Pressure	( )	( )	_____
High Cholesterol	( )	( )	_____
Thrombophlebitis	( )	( )	_____
CONGENITAL:			
Hereditary Defects	( )	( )	_____
DIGESTIVE:			
Diverticulosis	( )	( )	_____
Reflux	( )	( )	_____
Stomach Ulcers	( )	( )	_____
Irritable Bowel	( )	( )	_____
ENDOCRINE:			
Diabetes	( )	( )	_____
Thyroid Disease	( )	( )	_____
Anemia	( )	( )	_____
Liver Disease	( )	( )	_____

Illness:	Yes	No	Date
HEMATOLOGICAL:			
Bleeding Tendencies	( )	( )	_____
Blood Clots	( )	( )	_____
MUSCULOSKELETAL:			
Osteoporosis	( )	( )	_____
Osteopenia	( )	( )	_____
NEOPLASM:			
Cancer/Type _____	( )	( )	_____
NEUROLOGICAL:			
Convulsions / Seizures	( )	( )	_____
Migraines	( )	( )	_____
Stroke	( )	( )	_____
PSYCHIATRY:			
Mental Illness	( )	( )	_____
If Yes, Diagnosis: _____			
RESPIRATORY:			
Asthma	( )	( )	_____
Pneumonia	( )	( )	_____
Tuberculosis	( )	( )	_____
Rheumatic Fever	( )	( )	_____
SIGNS/SYMPTOMS:			
Glaucoma	( )	( )	_____
UROLOGY:			
Bladder Leakage	( )	( )	_____
Frequent Bladder Infections	( )	( )	_____
Kidney Infections	( )	( )	_____
Kidney Disease	( )	( )	_____
Kidney Stones	( )	( )	_____
Other: _____			

NAME_____ **DOB** _____ **AGE** _____ **DATE** _____

____ Single ____ Engaged ____ Married ____ Life partner ____ Lesbian ____ Separated ____ Divorced ____ Widow

GYNECOLOGIC HISTORY:

First day of last menstrual period: ____ / ____ / _____
# of days from one period to the next? _____
# of days your periods last? _____

Are your Periods:

Light ___ **Cramps with period:** *YES / NO*
Medium ___ **Excessive Bleeding:** *YES / NO*
Heavy ___ **Spotting between cycles:** *YES / NO*

Gender of sexual partners: M ___ and/or F ___
Are you currently sexually active? *YES / NO*
If Menopausal at what age? _____
Have you taken hormone replacement in the past? YES / NO
If so how long? _____

Have you been vaccinated against HPV? YES / NO
Number of injections: 1 ___ 2 ___ 3 ___

What are you using to prevent Pregnancy?

___ Birth control pills ___ Condoms ___ IUD ___ Diaphragm ___ Vasectomy ___ Tubal Ligation ___ Withdrawal
Other: _____

Sexual Orientation: Straight or Heterosexual ___ Bisexual ___ Lesbian, Gay, or Homosexual, ___ Other ___
Gender Identity: Female ___ Male ___ either male or female exclusively ___
Transgender female/Trans women/Male to female ___ Transgender male/Trans man/Female to male ___

Last Pap smear: ____ / ____ / _____ Results: _____ History of abnormal? *YES / NO*
Colonoscopy: ____ / ____ / _____ Results: _____
Bono Density: ____ / ____ / _____ Results: _____
Mammogram: ____ / ____ / _____ Results: _____ History of abnormal? *YES / NO*
Date of last flu shot: ____ / ____ / _____
If age 65, date of Pneumonia Vaccine: ____ / ____ / _____

Family History of Breast Cancer: *YES / NO* Whom: _____

MEDICATIONS (List all current medications that you are taking, including vitamins and herbal supplements):

DRUG	DOSAGE	FREQUENCY TAKEN

REVIEW OF SYSTEMS

CONST: Fatigue, body aches, weight loss, weight gain, fever, chills. night sweats	**CARDIO:** Chest pains, rapid or irregular heart beats
EYES: Impaired vision	**RESP:** Shortness of breath, cough
HENT: Headaches	**NEURO:** Muscular weakness, tingling or numbness
BREASTS: Lumps, swelling, tenderness, nipple discharge	**MUSC:** Joint pain, muscle pain
GI: Nausea. vomiting; diarrhea, constipation, abdominal pain, blood in stools, loss of appetite, hemorrhoids	**ENDO:** Heat or cold intolerance, excessive thirst
GU: Urgent or frequent urination, blood in urine, painful intercourse, vaginal discharge, genital sores, incontinence	**PSYCH:** Anxiety, depression, difficulty sleeping
INTEGUMENT: Rash, new or growing moles, excessive hair growth	**HEME/LYMPH:** Easy bruising, easy bleeding

Office use only*

Vital Signs: HT _____ WT _____ BP _____ /_____ G _____ P _____

LMP _____ BMI: _____

S/A _____ Cramps w menses: _____

SMOKER: Current / Previous / Never

IFOB: _____
HPV: _____
STD: _____
LDM: _____
ERX: _____
M/O: _____

PATIENT INFORMATION FORM