Atlanta Women's
OBSTETRICS & GYNECOLOGY, PC
Women Proudly Caring for Women

Annual Exam - Patient Medical History

Patient Name: _____

Birth Date: _____/_____/_____ **Age:** _____

Primary Physician: _____

Other Physician(s): _____

Allergies: _____

Preferred Pharmacy: _____

_____

Marital Status:

☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Never ☐ Previously, but quit ☐ Current packs/day _____

Alcohol Use: ☐ Yes ☐ Not Currently ☐ Never

Drinks per week: _____ Beer _____ Wine _____ Liquor

Drug Use: ☐ Never ☐ Type/Frequency: _____

Date of last period? _____/_____/_____

How long does your period last? _____ days

Do you have problems with PMS? ☐ YES ☐ NO

Are you periods regular? ☐ YES ☐ NO

Do you have pain with your periods? ☐ YES ☐ NO

Current sexual partner(s): ☐ Male ☐ Female ☐ Both

☐ Not currently sexually active

# of current partners: _____

Current Birth Control Method: _____

Do you have any problems with sex? ☐ YES ☐ NO

Do you have a history of abuse in your past or present? ☐ YES ☐ NO

Please list any medical changes, serious injuries, and/or surgeries performed since your last visit:

_____

_____

_____

_____

Please list all current Medications: (REQUIRED)

_____

_____

_____

_____

FAMILY MEDICAL HISTORY - Please update any changes since your last visit

	Age	Diseases	If Deceased, Cause Of Death
Father			
Mother			
Brother			
Sister			
Spouse			
Pat. Grandfather			
Pat. Grandmother			
Mat. Grandfather			
Mat. Grandmother			

REVIEW OF SYSTEMS

CONSTITUTIONAL	Yes	No
Weight gain	○	○
Weight loss	○	○
Fatigue	○	○
SKIN		
Rash	○	○
Itching	○	○
Breast pain	○	○
Breast lump	○	○
Breast discharge	○	○
CARDIOVASCULAR		
Chest Pains	○	○
Sudden heart beat changes / palpitations	○	○
Swelling of feet, ankles or hands	○	○
RESPIRATORY		
Frequent coughing	○	○
Shortness of breath	○	○
Wheezing	○	○
GASTROINTESTINAL		
Loss of appetite	○	○
Change in bowel movements	○	○
nausea or vomiting	○	○
Diarrhea	○	○
Constipation	○	○
Blood in stool	○	○
Stomach pain	○	○
Heartburn	○	○
URINARY		
Frequent urination	○	○
Burning or painful urination	○	○
Blood in urine	○	○
Incontinence	○	○
Urgency	○	○

ENDOCRINE	Yes	No
Excessive Thirst	○	○
Hot flashes	○	○
NEUROLOGICAL		
Frequent or recurring headaches	○	○
Light headed or dizzy	○	○
Numbness or tingling sensations	○	○
PSYCHIATRIC		
Nervousness	○	○
Depression	○	○
Sleep problems	○	○
MUSCULOSKELETAL		
Joint pain	○	○
Muscle pain or cramps	○	○
Back pain	○	○

GYNECOLOGICAL HISTORY

Age at first period _____

Date of last Pap _____

☐ premenopausal ☐ perimenopausal ☐ postmenopausal

Date of last mammogram _____ ☐ normal ☐ abnormal

Have your ever had:

☐ Herpes ☐ GC ☐ Chlamydia ☐ Venereal warts

Does your partner have Herpes or HPV? _____

Have you received the Gardasil® vaccination? ☐ Yes ☐ No

Have you ever had an abnormal Pap smear? _____ If yes, what happened?

_____

PREGNANCY HISTORY

☐ **Not Applicable**

Full Term: _____ # Premature: _____ # Miscarriages: _____ # Tubal Ectopic: _____

Abortions: _____ # Living Children: _____

BIRTH HISTORY

☐ **Not Applicable**

Date	Weeks pregnant	Delivery Type	Sex	Weight	Complications