East Georgia Women's Center *Welcome to our office!*

Name:_____ DOB:_____ Date:_____

PATIENT'S PERSONAL HISTORY

** When filling out this form be as detailed as possible, the more information you can provide for us the better we can meet your healthcare needs.*

What is the reason for your visit today?_____

What do you currently use for birth control? Please circle all that apply.

Pills Condoms Nuvaring IUD Depo Provera Tubal Ligation Abstinence Vasectomy

What was the first day of your last menstrual period?_____

Is your period usually light, moderate, or heavy. (circle)

What age did menstruation begin? _____How many days does your period last?_____

If you have begun menopause at what age did it start?_____

Medications List: (If you need additional space please ask front desk for medication list form)

Check if None: ☐

* Please include name of birth control pills, if taking.

Name of Medicine:	Strength:	How many times per day?	Prescribing Doctor:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any medications? If yes list them as well as the reaction that you have to the medicine. Check if None: ☐

_____, _____, _____

Are you allergic to Latex or Iodine? Circle all that apply. Check if None: ☐

Health Maintenance

When was your ….

Last Pap: _____ Last Bone Density: _____

Last Mammogram: _____ Last Cholesterol: _____

Last Colonoscopy: _____

Do you have any of these medical conditions? Circle all that apply.

Anemia Asthma Diabetes Thyroid Problems Depression/ Anxiety Gallbladder Problems Heart Problems

High Blood Pressure Kidney Problems Sickle Cell Disease/ Sickle Cell Trait Other:_____

Name:_____ DOB:_____ Date:_____

Past Surgeries

Have you ever had an operation? Circle those that apply to you.
* Please include those surgeries you had done even as a child.

Surgery	Date	Surgeon
Check if none of these: □		
Laparoscopy	_____	_____
Hysterectomy	_____	_____
D & C	_____	_____
Gallbladder	_____	_____
Ovarian cyst removal	_____	_____
Tubal pregnancy	_____	_____
Tubal Ligation	_____	_____
Appendix removed	_____	_____
Tonsils removed	_____	_____
C-Section	_____	_____
Wisdom teeth removed	_____	_____
Other	_____	_____

OB History:

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

Have you had twins, triplets, or more in the past? Circle all that apply.

How many of the following have you had: Ectopic Pregnancies:_____ Abortions:_____

Full Term Births: _____ Premature Births: _____ Miscarriages:_____

GYN History

Have you ever had any of the following problems? Circle all that apply.

Abnormal Pap Cancer Painful Menstruation Endometriosis

Fibroids Infertility Ovarian Cyst Pelvic Inflammatory Disease Urinary Leakage

Have you ever had?	Write Yes or No	Date	Treated?
Chlamydia	_____	_____	_____
Gonorrhea	_____	_____	_____
Herpes	_____	_____	_____
Syphilis	_____	_____	_____
HIV	_____	_____	_____
Other:_____	_____	_____	_____

Name:_____ DOB:_____ Date:_____

Social History:
Primary Language: _____ Marital Status: _____

Employer: _____ Occupation: _____

Spouses Name: _____ Spouse's Occupation: _____

Circle all that apply: Smoking: past present never If you currently smoke, how many packs per day? _____

If you smoked in the past, how long did you smoke? _____ When did you quit? _____

Alcohol Use: occasional regular never

Drug Use (ex. cocaine, marijuana, meth.): past present never What type of drug(s) did you use? _____

How often did you use these drugs?_____ How long did the drug use last? _____

Are you currently sexually active? Circle one. Yes or No

(Circle One) Exercise: some none regular

What kind of diet are you on? Regular Low fat Diabetic Low Salt Other_____

Family History:
Has anyone in your family ever had any of the following: Circle all that apply.

Condition	Father	Mother	Sister	Brother	Grandmother	Grandfather
Anemia	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Heart Problems	☐	☐	☐	☐	☐	☐

Other:_____

Self or Family Cancer Assessment
Circle all that apply.
Do you or does anyone in your immediate family have a history of….
Breast Cancer: Self Mother Sister

Ovarian Cancer: Self Mother Sister

Colon Caner: Self Mother Sister Father Brother