

ATLANTA MIDTOWN GYNECOLOGY PATIENT HISTORY SHEET

NAME: _____

DATE: ____/____/____

AGE: _____

BIRTHDATE: ____/____/____

1ST DAY OF LAST MENSTRUAL PERIOD: ____/____/____

REASON FOR VISIT: _____

ALLERGIES: _____

PAST MEDICAL HISTORY: (circle all that apply and describe if needed below)

- Hypertension Diabetes Thyroid Disease Kidney Disease Asthma Cancer
- Cholesterol Blood Clots Migraines Ulcers GERD (reflux) Stroke
- Depression Liver Disease Heart Disease Other: _____

PAST SURGICAL HISTORY: (circle all that apply and describe below if needed)

- Tonsils Appendix Gallbladder Tubal Ligation C-Section D+C Hysterectomy
- Other: _____

GYNECOLOGICAL HISTORY: (circle if apply)

Menstrual Hx: How often are your periods: every ____ days. / How long do they last: ____ days.
Any clots: YES / NO Do you have Cramps: NO / MILD / MODERATE / SEVERE
Are your periods LIGHT / MEDIUM / HEAVY

Pap Smear Hx: Have you ever had an ABNORMAL pap: YES / NO Did it require treatment: YES / NO
If Yes, what Treatment did you have: Cryo (freezing) / Laser (burning) / LEEP / CONE

STD Hx: none / Gonorrhea / Chlamydia / Herpes / Warts / Trichomonas / Hepatitis / Syphilis / HIV / PID

Birth Control: none / pills / patch / vaginal ring / Depo Provera / IUD / tubal ligation / condoms / other

Menopause: Have you gone thru menopause: YES / NO At what age: _____ If yes, are you on hormones: YES/NO

Sexual Hx: Are you sexually active: YES / NO If yes, with whom: Husband / Male / Female / Both

Other Gyn Hx: Fibroids / Endometriosis / Ovarian Cysts / OTHER: _____

OBSTETRICAL HISTORY: Number of.....

- Times Pregnant:** _____ **C-sections:** _____ **Miscarriage:** _____
- Full Term:** _____ **Vaginal:** _____ **Ectopic:** _____
- Preterm:** _____ **Abortions:** _____

SCREENING HISTORY: What year was your last.....(put none if never had)

Pap Smear: _____ Mammogram: _____ Cholesterol Check: _____
Diabetes Check: _____ Bone Density Scan: _____ Colonoscopy: _____

FAMILY HISTORY: (Check all that apply and describe below if needed)

- Heart Disease Hypertension Diabetes Thyroid Disease Cholesterol Stroke Kidney Disease
- Asthma Depression Liver Disease Breast Cancer Colon Cancer Ovarian Cancer
- Uterine Cancer Other: _____

SOCIAL HISTORY:

Are you a smoker: Yes / No / Past If Yes: _____ Pack/day If Past: Year Quit: _____
How much do you drink: None / Rare / Occasional / Social / Daily Any illicit drug use: Yes / No: _____
Any history of Abuse: None / Physical / Sexual / Emotional (circle what applies)
How much do you exercise: _____ # days per week

CURRENT MEDICATIONS: (list all medications and dosages) (list on back if more room needed)

- 1. _____ 2. _____
- 3. _____ 4. _____
- 5. _____ 6. _____