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

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

Current 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: _____

Gardasil Vaccination: Have you had the injection? YES / NO : Date of Last Injection: _____

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. _____