PATIENT HISTORY FORM

(Please Print)

YOUR NAME (Last) _____ (First) _____ (M.I.) _____

Date of Birth _____ REFERRED HERE BY _____

I attest that the information here is true and correct to the best of my belief.

_____ _____

Patient Signature Date

PAST MEDICAL HISTORY

(If YOU have EVER had any of these conditions, please indicate with an X or √)

Breast Conditions
_____Abnormal Mammogram
_____Breast Cancer ☐ Left ☐ Right
_____Breast Implants
_____Fibrocystic Breasts
_____Other _____

Gyn Problems
_____Abnormal Pap Smear
_____Cervical Cancer (Neoplasm)
_____Dysmenorrhea (Painful Menses)
_____Endometrial (Uterine) Cancer
_____Endometriosis
_____Fibroids
_____Herpes
_____Human Papilloma Virus Infection (HPV)
_____Ovarian Cancer
_____Ovarian Cysts
_____Pelvic Inflammatory Disease (PID)
_____Polycystic Ovarian Syndrome (PCOS)
_____Sexually Transmitted Disease (STD)
_____Vaginal Cancer (Neoplasm)
_____Vulvar Cancer (Neoplasm)
_____Other _____

Heart or Circulation Conditions (Cardiovascular)
_____Congenital Heart Disease
_____Congestive Heart Failure
_____Coronary Artery Disease
_____CVA (Stroke)
_____Hypertension (High Blood Pressure)
_____Irregular Heart Beat
_____Mitral Valve Disorders (MVP)
_____Pulmonary Embolism (Blood Clot in Lung)
_____Thrombophlebitis (Blood Clot in Extremity)

Endocrine (Glandular) Disorders
_____Diabetes – Type I (Insulin-Dependent)
_____Diabetes – Type II
_____Pituitary Gland Disorder
_____Thyroid Disease (Hypo) or (Hyper)
_____High Cholesterol
_____Other _____

Immune System Diseases
_____Chronic Fatigue Syndrome
_____Other _____

Gastrointestinal (GI) Problems
_____Colitis, Ulcerative
_____Crohn's Disease
_____Hepatitis A
_____Hepatitis B
_____Hepatitis C
_____Irritable Bowel Syndrome
_____Other _____

Blood (Hematologic) Disorders
_____Anemia
_____Bleeding Disorder
_____Clotting Disorder
_____Sickle Cell Trait or Disease
_____Thalassemia
_____Other _____

Musculoskeletal Disorders
_____Arthritis
_____Arthritis, Rheumatoid
_____Joint Pain
_____Fibromyalgia
_____Osteopenia
_____Osteoporosis
_____Scoliosis
_____Systemic Lupus Erythematosis
_____Other _____

Neurologic Disorders
_____Common Migraines
_____Headaches (Other)
_____Multiple Sclerosis
_____Seizure Disorder (Epilepsy)
_____TIA or Stroke
_____Other _____

Psychiatric or Emotional Conditions
_____ADHD/ADD
_____Bipolar (Manic-Depressive)
_____Major Depression
_____OCD (Obsessive-Compulsive)
_____Postpartum Depression
_____Severe Anxiety or Panic Attacks
_____Other _____

Respiratory (Lung) or ENT Disorders
_____Asthma
_____COPD
_____Lung Cancer
_____Pneumonia - Recurrent
_____Sleep Apnea
_____Tuberculosis
_____Other _____

Skin Conditions
_____Acne (severe)
_____Eczema
_____Hirsutism (Excess Hair Growth)
_____MRSA
_____Psoriasis
_____Other _____

Urinary (Urological) Disorders
_____Calculus (Kidney Stones)
_____Pyelonephritis
_____Stress Incontinence
_____Urge Incontinence/Overactive Bladder
_____Urinary Tract Infections (UTI)
_____Other _____

Genetic Disorders
_____Cystic Fibrosis
_____Muscular Dystrophy
_____Other _____

PAST SURGICAL HISTORY

(Please include any D&C, D&E, colposcopy, cryotherapy or colonoscopy surgeries)

Surgery	Reason	When

HERBS, VITAMINS AND SUPPLEMENTS YOU ARE TAKING

Product name	Dose (if known)	How Often	Start Date	Reason

MEDICATIONS YOU ARE TAKING

Drug name	Dose	How Often	Start Date	Prescribed by

Primary Pharmacy Name _____ phone # _____

Pharmacy Address: _____

ALLERGIES

Do you have any known medication allergies? YES NO

Allergic to any of the following (circle those that apply):

Contrast Dye Nickel Peanuts Latex Shellfish Other _____

If yes, please list all allergies here and the allergic reaction

Allergic to	**Reaction**

FAMILY MEDICAL HISTORY

(If **ANY** close relative of yours - such as brothers, sisters, parents, other children, grandparent (maternal or paternal), or aunt or uncle - has EVERHAD or CURRENTLYHAS any of the problems listed below, please ENTER AN X in the YES column and then enter the specific relationship to you.

Endometriosis	Yes	No	Who: Be specific	
Uterine Fibroids	Yes	No	Who: Be specific	
Breast Cancer	Yes	No	Who: Be specific	Age of diagnosis:
Colon Cancer	Yes	No	Who: Be specific	Age of diagnosis:
Heart Disease	Yes	No	Who: Be specific	
High Blood Pressure	Yes	No	Who: Be specific	
High Cholesterol	Yes	No	Who: Be specific	
Blood Clots	Yes	No	Who: Be specific	
Diabetes – Type I	Yes	No	Who: Be specific	
Diabetes – Type II	Yes	No	Who: Be specific	
Hyperthyroidism	Yes	No	Who: Be specific	
Hypothyroidism	Yes	No	Who: Be specific	
Lung Cancer	Yes	No	Who: Be specific	Age of diagnosis:
Bipolar Disorder	Yes	No	Who: Be specific	
Malignant Tumors (Site)			☐ Yes ☐ No Who: Be specific	
Ovarian Cancer	Yes	No	Who: Be specific	Age of diagnosis:
Uterine Cancer	Yes	No	Who: Be specific	Age of diagnosis:
Other Cancer (What Kind)			☐ Yes ☐ No Who: Be specific	Age of diagnosis:
Osteoporosis	☐ Yes	☐ No	Who: Be specific	

MENSTRUAL HISTORY

AGE of FIRST MENSTRUAL PERIOD _____ CYCLE LENGTH (28 days or ?) _____

# of DAYS of BLEEDING with a PERIOD _____ PERIOD FLOW: Light Medium Heavy

DATE of LAST NORMAL MENSTRUAL PERIOD (if abnormal, describe) _____

BIRTH CONTROL METHOD USING NOW _____

(*period means # days of bleeding; cycle length means total # of bleeding and non-bleeding days until the next period begins)

MENOPAUSE STATUS: PREMENOPAUSAL POSTMENOPAUSAL PERIMENOPAUSAL AGE MENOPAUSE_____

PREGNANCY SUMMARY (how many…?)

Total Number of Pregnancies	Full Term Births (> 37 wks)	Premature Births (< 37 wks)	Terminations	Miscarriages Was Surgery Needed?	Ectopic pregnancies Left or Right?	Number of Living Children

Please provide date of terminations, miscarriages and ectopic pregnancies.

Comments: _____

PREGNANCY DETAILS

Child's Birthdate MM/DD/YY	Child's Name	# weeks at Delivery	Length of Labor	Birth Wt.	M or F	Type of Delivery (Vaginal or C/S)	Anesth-esia	Complications/ Problems	Physician	Location

SOCIAL HISTORY

Marital Status: ☐ Dating ☐ Divorced ☐ Engaged ☐ Married ☐ Not Dating ☐ Separated ☐ Single ☐ Widowed

Alcohol Use: ☐ Never ☐ Current ☐ Former How Much: _____

____Age started ____Age stopped

Illegal Drug Use: ☐ Never ☐ Current ☐ Former Which Drug(s): _____

How Often: _____ ___ Age started ___ Age stopped _____When last used

Tobacco Use: ☐ Never ☐ Current ☐ Former How Much: _____

___Age started ___Age stopped

Caffeine Use: ☐ Never ☐ Current ☐ Former How Much: _____

___Age started ___Age stopped

Exercise Habits: ☐ Active but no formal exercise ☐ Heavy amount of exercise (4 or more times weekly)

☐ Minimal amount of exercise (Once weekly or less) ☐ Moderate amount of exercise (1-3 times weekly) ☐ Sedentary

Type of exercise: _____

Occupation: _____

Hobbies: _____

Notes: _____

GENERAL INFORMATION REQUIRED

Which method do you prefer our office to leave a message regarding your care, appts, etc.?

Home- Yes_____ No_____ E-Mail- Yes_____ No_____
Cell- Yes_____ No_____
Work- Yes_____ No_____ Answer Machine- Yes_____ No_____

For the privacy of our patients, information regarding your care will not be discussed or released to friends, family members, co-workers, etc. unless authorized by the patient. Please list the person(s) below that you authorize Gynecology Associates to release medical information to.

Name:_____ Relationship_____
Name:_____ Relationship_____

I have been offered a copy of the Central Georgia Health Systems Notice of Privacy Practices?
Yes___ No__

I CERTIFY THAT THE INFORMATION GIVEN BY ME ABOVE IS CORRECT. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION TO ANY THIRD PARTY PAYORS TO BE USED BY THEM IN CONSIDERATION OF A PAYMENT OF ANY CLAIM RESULTING FROM MY TREATMENT. I ALSO AUTHORIZE RELEASE OF SAID INFORMATION TO AND FROM MY PHYSICIANS, STATE OR FEDERAL AGENCIES, OR OTHER HEALTHCARE PROVIDERS IF NEEDED FOR SUCH PROFESSIONAL STAFF AND AIDES IT MAY DESIGNATE TO CARRY OUT SUCH PROCEDURES, TO ADMINISTER TREATMENT, AND PERFORM SUCH CARE AS NEEDED. I CONSENT TO THE PERFORMANCE OF THOSE MEDICAL TREATMENTS AND/OR PROCEDURES IN ADDITION TO OR DIFFERENT FROM THOSE NOW COMTEMPLATED THAT MAY ARISE FROM PRESENTLY UNFORSEEN CONDITIONS THAT MAY OCCUR DURING MY TREATMENT. I FURTHER UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR ANY BALANCE DUE AFTER INSURANCE HAS BEEN FILED.

Signature of Patient:_____Date:_____/_____/_____