Peachtree City Obstetrics and Gynecology, P.C.

FOR OFFICE USE ONLY

☐ NEW PATIENT ☐ ESTABLISHED PATIENT ☐ CONSULTATION ☐ REPORT SENT: / /

OB/GYN COMPREHENSIVE PATIENT INTAKE HISTORY

PATIENT NAME:	AGE:	BIRTHDATE / /	DATE: / /
RACE: ☐ CAUCASIAN ☐ AFRICAN-AMERICAN ☐ OTHER			
REFERRED BY:			PCP:
WHY HAVE YOU COME TO THE OFFICE TODAY?			
IS THIS A NEW PROBLEM?			
PLEASE DESCRIBE YOUR PROBLEM, INCLUDING WHERE IT IS, HOW SEVERE IT IS AND HOW LONG IT HAS LASTED.			

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your Provider.

				PROVIDER NOTES
LAST NORMAL MENSTRUAL PERIOD (FIRST DAY) / /				
AGE PERIODS BEGAN:				
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING)				
NUMBER OF DAYS BETWEEN PERIODS:				
ANY RECENT CHANGES IN PERIOD?				
ARE YOU CURRENTLY SEXUALLY ACTIVE?				
HAVE YOU EVER HAD SEX?				
NUMBER OF SEXUAL PARTNERS (LIFETIME)				
PRESENT METHOD OF BIRTH CONTROL				
HAVE YOU EVER USED:	YES	NO	IF YES, HOW LONG?	
INTRAUTERINE DEVICE (IUD)	☐	☐		
BIRTH CONTROL PILLS	☐	☐		
DEPO PROVERA	☐	☐		
VAGINAL RING	☐	☐		
PATCH	☐	☐		
IMPLANON	☐	☐		
WHEN WAS YOUR LAST PAP TEST?				
WHAT WAS THE RESULT?				
HAVE YOUR EVER HAD AN ABNORMAL PAP TEST? **☐Yes ☐No** HAVE YOU BEEN EXPOSED TO DIETHYLSTILBESTROL? (DES) **☐Yes ☐No**				
DO YOU DO BREAST SELF-EXAMINATIONS? **☐Yes ☐No** WHEN WAS YOUR LAST MAMMOGRAM? (DATE)_____				
WHEN WAS YOUR LAST COLORECTAL SCREEN? (DATE)_____ WHEN WAS YOUR LAST BONE DENSITY SCAN? (DATE)_____				

PATIENT NAME: BIRTHDATE: / / DATE: / /

OBSTETRIC HISTORY

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS (<37 WEEKS)		LIVE BIRTHS		LIVING CHILDREN	
ANY PREGNANCY COMPLICATIONS?					
☐ DIABETES ☐ HYPERTENSION/HIGH BLOOD PRESSURE ☐ PREECLAMPSIA/TOXEMIA ☐ OTHER					
ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? ☐ NO ☐ YES, HOW TREATED					

CURRENT MEDICATIONS

(Including hormones, vitamins, herbs, nonprescription medications)

DRUG NAME AND DOSAGE	WHO PRESCRIBED	DRUG NAME AND DOSAGE	WHO PRESCRIBED

FAMILY HISTORY

MOTHER ☐ LIVING ☐ DECEASED-CAUSE AGE: FATHER ☐ LIVING ☐ DECEASED-CAUSE AGE:

SIBLINGS: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGES:

CHILDREN: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGES:

ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET	PROVIDER NOTES
DIABETES	☐		
STROKE	☐		
HEART DISEASE	☐		
BLOOD CLOTS IN LUNGS OR LEGS	☐		
HIGH BLOOD PRESSURE	☐		
HIGH CHOLESTEROL	☐		
OSTEOPOROSIS (WEAK BONES)	☐		
HEPATITIS	☐		
HIV/AIDS	☐		
TUBERCULOSIS	☐		
BIRTH DEFECTS	☐		
ALCOHOL OR DRUG PROBLEMS	☐		
BREAST CANCER	☐		
COLON CANCER	☐		
UTERINE CANCER	☐		
MENTAL ILLNESS/DEPRESSION	☐		
ALZHEIMER'S DISEASE	☐		
OTHER	☐		

COMPREHENSIVE PATIENT INTAKE HISTORY (Continued)

PATIENT NAME: BIRTHDATE: / / DATE: / /

SOCIAL HISTORY

	YES	NO	PROVIDER NOTES
EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:	☐	☐	
ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK: TYPE OF DRINK:	☐	☐	
DRUG USE	☐	☐	
SEAT BELT USE	☐	☐	
REGULAR EXERCISE: HOW LONG AND HOW OFTEN?	☐	☐	
DAIRY PRODUCT INTAKE AND/OR CALCIUM SUPPLEMENTS: DAILY INTAKE:	☐	☐	
HEALTH HAZARDS AT HOME OR WORK?	☐	☐	
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE?	☐	☐	
DO YOU HAVE AN ADVANCED DIRECTIVE (LIVING WILL)?	☐	☐	
ARE YOU AN ORGAN DONOR?	☐	☐	

PERSONAL PROFILE

YOUR CHOICE OF SEXUAL PARTNERS? ☐ MEN ☐ WOMEN ☐ BOTH
MARITAL STATUS: ☐ MARRIED ☐ LIVING WITH PARTNER ☐ SINGLE ☐ WIDOWED ☐ DIVORCED
NUMBER OF LIVING CHILDREN:
NUMBER OF PEOPLE IN HOUSEHOLD:
SCHOOL COMPLETED: ☐ HIGH SCHOOL ☐ SOME COLLEGE/AA DEGREE ☐ COLLEGE ☐ GRADUATE DEGREE ☐ OTHER
CURRENT OR MOST RECENT JOB:
TRAVEL OUTSIDE THE UNITED STATES?

PERSONAL PAST HISTORY OF ILLNESS

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PROVIDER NOTES
ASTHMA		☐	☐	
PNEUMONIA/LUNG DISEASE		☐	☐	
KIDNEY INFECTIONS/STONES		☐	☐	
TUBERCULOSIS		☐	☐	
FIBROIDS		☐	☐	
SEXUALLY TRANSMITTED DISEASE/CHLAMYDIA		☐	☐	
INFERTILITY		☐	☐	
HIV/AIDS		☐	☐	
HEART ATTACK/DISEASE		☐	☐	
DIABETES		☐	☐	
HIGH BLOOD PRESSURE		☐	☐	
STROKE		☐	☐	
RHEUMATIC FEVER		☐	☐	
BLOOD CLOTS IN LUNGS OR LEGS		☐	☐	
EATING DISORDERS		☐	☐	
AUTOIMMUNE DISEASE (LUPUS)		☐	☐	
CHICKENPOX		☐	☐	
CANCER		☐	☐	
REFLUX/HIATAL HERNIA/ULCERS		☐	☐	
DEPRESSION/ANXIETY		☐	☐	
ANEMIA		☐	☐	
BLOOD TRANSFUSIONS		☐	☐	
SEIZURES/CONVULSIONS/EPILEPSY		☐	☐	
BOWEL PROBLEMS		☐	☐	
GLAUCOMA		☐	☐	
CATARACTS		☐	☐	
ARTHRITIS/JOINT PAIN/BACK PROBLEMS		☐	☐	
BROKEN BONES		☐	☐	
OSTEOPENIA/OSTEOPOROSIS		☐	☐	
HEPATITIS/YELLOW JAUNDICE/LIVER DISEASE		☐	☐	
THYROID DISEASE		☐	☐	

PATIENT NAME: BIRTHDATE: / / DATE: / /

PERSONAL PAST HISTORY OF ILLNESSES (Continued)

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PROVIDER NOTES
GALLBLADDER DISEASE				
HEADACHES				
DES EXPOSURE				
INFERTILITY				
BLEEDING DISORDERS				
OTHER				

OPERATIONS/HOSPITALIZATIONS

REASON	DATE	HOSPITAL
1.		
2.		
3.		
4.		
5.		

INJURIES/ILLNESS

TYPE	DATE	TYPE	DATE
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

IMMUNIZATIONS/TEST

	DATE		DATE
TETANUS-DIPHTERIA BOOSTER		INFLUENZA VACCINE (FLU SHOT)	
HEPATITIS A VACCINE		HEPATITIS B VACCINE	
VARICELLA (CHICKENPOX) VACCINE		PNEUMOCOCCCAL (PNEUMONIA) VACCINE	
MEASLES-MUMPS-RUBELLA (MMR) VACCINE		TUBERCULOSIS (TB) SKIN TEST: RESULT:	
GARDASIL: **#1** / / **#2** / / **#3** / /			

PROVIDER NOTES:

PATIENT NAME: BIRTHDATE: / / DATE: / /

REVIEW OF SYSTEMS

Please check (x) if any of the following symptoms apply to you now or since adulthood (Age 18)

	NOW	PAST	NOT SURE	PROVIDER NOTES
1. **CONSTITUTIONAL**				
WEIGHT LOSS	☐	☐	☐	
WEIGHT GAIN	☐	☐	☐	
FEVER	☐	☐	☐	
FATIGUE	☐	☐	☐	
CHANGE IN HEIGHT	☐	☐	☐	
2. **EYES**				
DOUBLE VISION	☐	☐	☐	
SPOTS BEFORE EYES	☐	☐	☐	
VISION CHANGES	☐	☐	☐	
GLASSES/CONTACTS	☐	☐	☐	
3. EAR, NOSE, AND THROAT				
EARACHES	☐	☐	☐	
RINGING IN EARS	☐	☐	☐	
HEARING PROBLEMS	☐	☐	☐	
SINUS PROBLEMS	☐	☐	☐	
SORE THROAT	☐	☐	☐	
MOUTH SORES	☐	☐	☐	
DENTAL PROBLEMS	☐	☐	☐	
4. CARDIOVASCULAR				
CHEST PAIN OR PRESSURE	☐	☐	☐	
DIFFICULTY BREATHING ON EXERTION	☐	☐	☐	
SWELLING OF LEGS	☐	☐	☐	
RAPID OR IRREGULAR HEARTBEAT	☐	☐	☐	
5. RESPIRATORY				
PAINFUL BREATHING	☐	☐	☐	
WHEEZING	☐	☐	☐	
SPITTING UP BLOOD	☐	☐	☐	
SHORTNESS OF BREATH	☐	☐	☐	
CHRONIC COUGH	☐	☐	☐	
6. GASTROINTESTINAL				
FREQUENT DIARRHEA	☐	☐	☐	
BLOODY STOOL	☐	☐	☐	
NAUSEA/VOMITING/INDIGESTION	☐	☐	☐	
CONSTIPATION	☐	☐	☐	
INVOLUNTARY LOSS OF GAS OR STOOL	☐	☐	☐	
7. GENITOURINARY				
BLOOD IN URINE	☐	☐	☐	
PAIN WITH URINATION	☐	☐	☐	
STRONG URGENCY TO URINATE	☐	☐	☐	
FREQUENT URINATION	☐	☐	☐	
INCOMPLETE EMPTYING	☐	☐	☐	
INVOLUNTARY -UNINTENDED URINE LOSS	☐	☐	☐	
URINE LOSS WHEN COUGHING/LIFTING	☐	☐	☐	
ABNORMAL BLEEDING	☐	☐	☐	
PAINFUL PERIODS	☐	☐	☐	

PATIENT NAME: BIRTHDATE: / / DATE: / /

REVIEW OF SYSTEMS (Continued)

	NOW	PAST	NOT SURE	PROVIDER NOTES
7. GENITOURINARY (Continued)				
PREMENSTRUAL SYNDROME (PMS)	☐	☐	☐	
PAINFUL INTERCOURSE	☐	☐	☐	
ABNORMAL VAGINAL DISCHARGE	☐	☐	☐	
8. MUSCULOSKELETAL				
MUSCLE WEAKNESS	☐	☐	☐	
MUSCLE OR JOINT PAIN	☐	☐	☐	
OSTEOPOROSIS	☐	☐	☐	
9a. SKIN	☐	☐	☐	
RASH	☐	☐	☐	
SORES	☐	☐	☐	
DRY SKIN	☐	☐	☐	
MOLES (GROWTH OR CHANGES)	☐	☐	☐	
9b. BREASTS				
PAIN IN BREAST	☐	☐	☐	
NIPPLE DISCHARGE	☐	☐	☐	
LUMPS	☐	☐	☐	
10. NEUROLOGIC				
DIZZINESS	☐	☐	☐	
SEIZURES	☐	☐	☐	
NUMBNESS	☐	☐	☐	
TROUBLE WALKING	☐	☐	☐	
MEMORY PROBLEMS	☐	☐	☐	
FREQUENT HEADACHES	☐	☐	☐	
11. PSYCHIATRIC				
DEPRESSION OR FREQUENT CRYING	☐	☐	☐	
ANXIETY	☐	☐	☐	
12. ENDOCRINE				
HAIR LOSS	☐	☐	☐	
HEAT/COLD INTOLERANCE	☐	☐	☐	
ABNORMAL THIRST	☐	☐	☐	
HOT FLASHES	☐	☐	☐	
13. HEMATOLOGIC/LYMPHATIC				
FREQUENT BRUISES	☐	☐	☐	
CUTS DO NOT STOP BLEEDING	☐	☐	☐	
ENLARGED LYMPH NODES (GLANDS)	☐	☐	☐	
14. ALLERGIC/IMMUNOLOGIC				
MEDICATION ALLERGIES	☐	☐	☐	
IF ANY, PLEASE LIST ALLERGY AND TYPE OF REACTION				
LATEX ALLERGY	☐	☐	☐	
OTHER ALLERGIES	☐	☐	☐	
PLEASE LIST ALLERGY AND TYPE OF REACTION				

FORM COMPLETED BY ☐ **PATIENT** ☐ **OFFICE NURSE** ☐ **PROVIDER** ☐ **OTHER**

SIGNATURE OF PATIENT:

DATE REVIEWED BY PROVIDER WITH PATIENT: / / PROVIDER SIGNATURE:

ANNUAL REVIEW OF HISTORY: DATE REVIEWED: / / PROVIDER SIGNATURE: DATE REVIEWED: / / PROVIDER SIGNATURE:

DATE REVIEWED: / / PROVIDER SIGNATURE: DATE REVIEWED: / / PROVIDER SIGNATURE: