

Peachtree City Obstetrics and Gynecology, PC

Today's Date: _____

Name: _____ Date of Birth _____ Age: _____

Reason for Today's visit _____

Menstrual History:

First Day of Last Menstrual Period: _____ Age at First Menstrual Period: _____ Years

Number of days from the start of one period to the start of the next: _____ days

Number of days that you bleed: _____ days

Describe the amount of menstrual flow (circle one) _____ light / moderate / heavy / clots

How many tampons or pads do you use on your heaviest day? _____

Describe the amount of menstrual discomfort (circle one) _____ none / mild / moderate / severe

Do you bleed in between your periods? (circle one) Yes No

Do you bleed after intercourse? (circle one) Yes No

If you stopped menstruating, at what age did you stop? _____ years

Have you had bleeding or spotting since your periods stopped? (circle one) Yes No

Contraceptive and Sexual History:

Present birth control method: _____

Birth Control Methods used in the past:

Method	Length of Use	Reason for Discontinuation
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

Are you or have you ever been sexually active (had intercourse)? (circle one) Yes No

Have you had a new sexual partner in the past three months? (circle one) Yes No

Is/Are your sexual partner(s) male, female or both? (circle one) Male Female Both

Do you experience pain or discomfort with sexual intercourse? (circle one) Yes No

Pap Smear/Mammogram History

Date of Last Pap Smear _____ Have you had abnormal pap smears? (circle one) Yes No

Have you had treatment for abnormal smears? (circle one) Yes No

If yes, what type(s) of treatment have you had?

Cryotherapy Year _____ Laser Year _____

Cone Biopsy Year _____ Loop Excision (LEEP) Year _____

Other Past Gynecology History: Circle any that apply: None Pelvic Inflammatory Disease Endometriosis

Venereal Warts Herpes-genital Syphilis Gonorrhea Chlamydia

Vaginal Infections Other _____

Date of last mammogram Month _____ Year _____

Have you had an abnormal mammogram? (circle one) Yes No

Name: _____ DOB: _____ Date: _____

Obstetrical History: Please record the number of:

Pregnancies _____ Vaginal Births _____ Miscarriages _____
Living Children _____ C-Sections _____ Abortions _____

List any complications of pregnancies: _____

Medical History: Please check if you or a blood-relative have had any of the following:

	Myself	Family		Myself	Family		Myself	Family
Anemia	_____	_____	Mental Illness	_____	_____	Liver Disease/Hepatitis	_____	_____
High Blood Pressure	_____	_____	Depression	_____	_____	Gall Bladder Disease	_____	_____
High Cholesterol	_____	_____	Anxiety	_____	_____	Blood Clots in Veins/Lungs	_____	_____
Heart Disease	_____	_____	Eating Disorder	_____	_____	Blood Transfusion	_____	_____
Stroke	_____	_____	Migraine Headaches	_____	_____	Breast Cancer	_____	_____
Diabetes	_____	_____	Urinary Tract Infection	_____	_____	Colon Cancer	_____	_____
COPD/Emphysema	_____	_____	Lupus	_____	_____	Uterine Cancer	_____	_____
Asthma	_____	_____	Arthritis	_____	_____	Ovarian Cancer	_____	_____
Seizures	_____	_____	Back Injury	_____	_____	Other Cancer, specify	_____	_____
Thyroid problems	_____	_____	Osteoporosis	_____	_____			

Other Medical Problems: (List all) _____

Past Obstetrical/Gynecological Surgeries None _____

	Year		Year
D&C	_____ _____ _____ _____ _____ _____ _____ _____	Ovarian Surgery	_____ _____ _____ _____ _____ _____ _____ _____
Hysteroscopy		L cyst(s) removed ovarian	
Infertility Surgery		R cyst(s) removed ovarian	
Tubal Ligation		L ovary removed	
Laparoscopy		R ovary removed	
Hysterectomy (Vaginal)		Vaginal or Bladder Repair	
Hysterectomy (Abdominal)		For prolapsed or incontinence	
Myomectomy		Cesarean section	
		Other	

Past Surgical History (Not Ob/Gyn)

List all surgeries and their year or None _____

Surgeries	Year	Surgeries	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is there any other information you feel we should have:

Patient Signature _____ Date _____ Provider Signature _____ Date _____

