**GWINNETT PHYSICIANS GROUP OB/GYN** **DATE** _____

**NAME:** _____ **DOB:** _____

**MEDICAL HISTORY**

Age of first menstrual period: _____ How often do you have your period: _____

How would you describe your period? ☐ Light ☐ Mild ☐ Heavy Do you have pain with periods? ☐ Yes ☐ No

Vaginal Infections? Yeast ☐ Trichomonas ☐ Other _____

Date of last menstrual period: _____ Length: _____

Date of last Pap smear: _____ Results: _____

Date of last mammogram: _____ Results: _____

**Urinary problems**: ☐ Urgency ☐ Frequency ☐ Pain during urination ☐ Loss of urine when coughing, sneezing or laughing

**Other problems:** Pelvic pain ☐ Irregular Vaginal bleeding ☐ Abnormal Pap Smears ☐ Infertility ☐ Pelvic infections ☐

☐ Recent unexplained weight loss ☐ Weight gain ☐ No ☐ Yes How much? _____

**Cough for more than 3 weeks**: · No · Yes **Fever**: · No · Yes **Coughing blood:** · No Yes **Night Sweats:** · No · Yes

**Sexual History**: Age when sexual activity began _____ Number of current partners _____ Total number of partners _____

☐ Pain with intercourse ☐ Satisfied ☐ Sexual Dysfunction Contraceptive Method _____

| | **Do you or have you ever had any of the following conditions?** | | **Does anyone in your family have any of the following conditions?** | |
|---|---|---|---|---|
| | **Yes** | **No** | **Yes** | **No** |
| Bleeding Problem | | | | |
| Cancer | | | | |
| Diabetes | | | | |
| Genetic Disorder | | | | |
| Heart Problem | | | | |
| Hepatitis | | | | |
| High Blood Pressure | | | | |
| Lung Problem | | | | |
| Muscle/Bone Musculoskeletal problem | | | | |
| Neurological Problem | | | | |
| Emotional Problems | | | | |
| Stomach/Bowel Problem | | | | |
| Thyroid Problem | | | | |

**Food/Drug Allergies**:_____ **Current Medications**: _____

**What subject do you need more information on?** ☐ Diagnosis/Condition/Treatment ☐ Medications/Pain Management ☐ Other _____

**How do you learn best?** ☐ Demonstration ☐ Verbal Explanation ☐ Audio/Visual ☐ Printed Material ☐ Groups

**Hospitalization or Surgeries**

Please list any past surgeries or hospitalization, include date and name of hospital.

**Pregnancy History-Past Pregnancies**

| | **Date Mo/Yr** | **GA Weeks** | **Length of Labor** | **Birth Weight** | **Sex M/F** | **Type of Delivery** | **Anesthesia** | **Place of Delivery** | **Preterm Labor Yes/No** | **Comments/ Complications** |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |

**OFFICE USE ONLY**

Date Reviewed: _____

Signature: _____