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: _____