

For back office staff only:

Weight _____

Height _____

Blood pressure _____

Atlanta Women's Specialists
Initial Patient Information

Name: _____ Date: _____

Occupation: _____ Date of Birth: _____ Age: _____ Marital Status: _____

Ethnicity: _____ Referred By: _____ Date of last menstrual period: _____

Please list your pharmacy name and phone number where you would like your prescription refills to be called in for you: _____

Reason for visit

Routine Physical (Pap smear, pelvic exam and breast exam)

Problem (please describe): _____

Allergies

Please list allergies to medications, if any, and what type of reaction you had to that medicine:

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Will you accept blood products in the event of an emergency?: No Yes

Family History

Please indicate if you have a family history of any of the following conditions. Please specify whether the affected relative is on your maternal or paternal side of the family:

	Family (relationship)		Family (relationship)		Family (relationship)
Breast Cancer	<input type="checkbox"/> _____	Colon Cancer	<input type="checkbox"/> _____	Cervical Cancer	<input type="checkbox"/> _____
Ovarian Cancer	<input type="checkbox"/> _____	Uterine Cancer	<input type="checkbox"/> _____	Heart Disease	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____	High Blood Pressure	<input type="checkbox"/> _____	Osteoporosis	<input type="checkbox"/> _____
Stroke	<input type="checkbox"/> _____	Thyroid Disease	<input type="checkbox"/> _____		

I do not know my family history.

I do not have any significant family history.

Other Medical Problems (please list): _____

Past Medical History

Indicate if you have, or have ever had, any of the following:

___ Asthma	___ Genital Herpes	___ Infertility
___ Breast Cancer	___ Genital Warts	___ Migraines
___ Chlamydia	___ Gonorrhea	___ Mitral Valve Prolapse
___ Blood Clots	___ Heart Disease	___ Osteoporosis
___ Depression	___ Hepatitis	___ Pelvic Inflammatory Disease
___ Diabetes	___ High Blood Pressure	___ Stroke
___ Eating Disorder	___ High Cholesterol	___ Thyroid Disease
___ Endometriosis	___ HIV/AIDS	___ Uterine Fibroids

Other medical history (please list): _____

Have you ever had a pap smear? NO YES If yes, when? _____

Have you ever had an abnormal pap smear?

NO YES If yes, when? _____ What type of treatment was required? _____

Have you ever had a mammogram? NO YES If yes, when? _____

Please list any previous surgeries: _____

Sexual History

Are you sexually active currently? YES NO

What do you use to prevent pregnancy? _____

Do you have pain, discomfort or other problems with intercourse? YES NO

Social History

Do you smoke cigarettes? YES NO

How many per day? _____

Have you smoked cigarettes? YES NO

When did you quit? _____

Do you drink alcohol? YES NO

How many drinks per day? _____ Per week? _____

Do you use Street Drugs? YES NO

How often? _____

What kind of street drugs? _____

Do you get any regular exercise (describe)? _____

Have you been emotionally or physically abused by your partner or someone important to you? _____

Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone? _____

Medications

Please list medication(s) that you take regularly (prescribed or over the counter):

1. _____

2. _____

3. _____

Obstetrical History

Number of pregnancies _____

Number of preterm births _____

Number of full term births _____

Number of living children _____

Number of abortions _____

Number of miscarriages _____

Number of ectopic/tubal pregnancies _____

	First Delivery	Second Delivery	Third Delivery	Fourth Delivery	Fifth Delivery
Date of delivery					
Gestational age at delivery					
Type of delivery					
Pregnancy or delivery complications? If so, please list.					
Birth weight					

While signing up for *My Health Portfolio* is the best way to contact the office, at times it may be necessary to call you to relay messages from your healthcare provider. Please list a phone number(s) where we can best reach you: _____

Can we leave detailed messages at this number? YES NO

Thank you for taking time to provide complete information.

Atlanta Women's Specialists

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