

Modern Obstetrics & Gynecology of North Atlanta, P.C.

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NEW PATIENT MEDICAL HISTORY FORM

The following information is very important to your health. Please take the time to fully and completely fill out this important information. We are counting on you.

Patient Name _____ Age _____ Height _____ Birth Date _____ Date _____

Chief Complaint: _____

List present medications/supplements: _____

List all medication allergies: _____

Pharmacy Name _____ Phone# _____ Location _____

Family History

| | | <u>Cause of Death</u> | <u>Age</u> |
|--------------------|-------------------------------|-----------------------|------------|
| Your Father | Living / Deceased | | |
| Your Mother | Living / Deceased | | |
| # of Your Siblings | #Living ____ / #Deceased ____ | | |

Do you have a **Family History** of:

| | <u>NO</u> | <u>YES</u> | <u>Please Explain</u> |
|---------------------------|-----------|------------|-----------------------|
| Anemia | | | |
| Arthritis | | | |
| Blood Transfusions | | | |
| Bowel Disorders | | | |
| Breast Disease | | | |
| Cancer | | | |
| Chicken Pox | | | |
| Diabetes | | | |
| DES Exposure | | | |
| Endometriosis | | | |
| Excessive Bleeding | | | |
| Gall Bladder | | | |
| H. Hernia/Peptic Ulcer | | | |
| Headache/Migraine | | | |
| Heart Disease | | | |
| Hypertension | | | |
| Infertility | | | |
| Jaundice/Hepatitis | | | |
| Kidney Disease | | | |
| Respiratory Disease | | | |
| Psych. Illness/Depression | | | |
| Seizure Disorder | | | |
| Skin Disease | | | |
| Thyroid Disease | | | |
| Urinary Infections | | | |
| Varicose Veins/Phlebitis | | | |

Past Surgical History:

| <u>Date</u> | <u>Procedure</u> |
|-------------|------------------|
| | |
| | |
| | |

Illness History (Other than Surgical Procedures):

| <u>Date</u> | <u>Illness</u> |
|-------------|----------------|
| | |
| | |
| | |

Tests

| <u>Test</u> | <u>Year Performed</u> | <u>Not Sure</u> | <u>Never Done</u> | <u>Results</u> |
|-----------------|-----------------------|-----------------|-------------------|----------------|
| Pap Smear | | | | |
| Breast Exam | | | | |
| Mammogram | | | | |
| Rectal Exam | | | | |
| Sigmoidoscopy | | | | |
| Colonoscopy | | | | |
| Cholesterol | | | | |
| Rubella | | | | |
| Triglycerides | | | | |
| Thyroid Profile | | | | |
| Tetanus (DPT) | | | | |
| Bone Density | | | | |
| Other _____ | | | | |

Menstrual Periods:

Age Onset _____ Are you experiencing heavy bleeding with your periods? Y / N
 Date of Last Period _____ Are you experiencing loss of urine with coughing, laughing, straining, etc.? Y / N
 Periods: Regular _____ Irregular _____ Would you like to discuss this with your doctor? Y / N

Pregnancies:

of Children Born Alive _____ # of Cesarean Sections _____
 # of Premature Births _____ # of Stillborns _____
 # of Miscarriages _____ # of Abortions _____

Your Personal Habits:

| | <u>Yes</u> | <u>No</u> | <u>Please Explain</u> |
|--|------------|-----------|-----------------------|
| Do you exercise regularly (3 to 4 times per week)? | | | |
| Do you use illegal drugs? | | | |
| Do you use alcohol? | | | |
| Were you ever a heavy drinker? | | | |
| Do you smoke? | | | |
| If ever, when did you stop? | | | |
| Do you have an eating disorder? Anorexia _____ Bulimia _____ | | | |
| Have you ever been physically abused? | | | |
| Are you currently being physically abused? | | | |
| Do you feel safe in your home? | | | |
| Do you have sex with: men _____ women _____ both _____ | | | |
| Any concerns? | | | |

My signature indicates that the above information is true and correct to the best of my knowledge.

Patient Signature _____ **Date** _____