Patient History	Name:	Date of Birth:

Personal History of Past Illness

Major Illness	Yes (Date)	Major Illness	Yes (Date)
Anemia		Glaucoma	
Arthritis / Joint Pain		Headaches (chronic only)	
Asthma		Heart Disease	
Back Problems		Hepatitis/Yellow Jaundice/Liver Disease	
Blood Clot in Lungs or Legs		High Blood Pressure	
Blood Transfusions		High Cholesterol	
Bowel Problems		HIV/Aids	
Broken Bones		Kidney Infection/Kidney Stones	
Cancer		Pneumonia/Lung Disease	
Cataracts		Reflux/Hiatal Hernia/Ulcer	
Chickenpox		Rheumatic Fever	
Collagen Vascular Disease (Lupus)		Seizures/Convulsions/Epilepsy	
Depression or Anxiety (circle)		Sexually Transmitted Disease	
Diabetes		Stroke	
Eating Disorders		Thyroid Disease	
Gallbladder Disease		Tuberculosis	
Other			

GYN History

Abnormal Hair Growth			Infertility		
Abnormal Bleeding			Ovarian Cyst		
Abnormal Pap Smear			Osteoporosis		
Breast Problems			Sexual Problems		
Cyst of Vulva			Sexually Transmitted Disease		
DES Exposure			Uterine Abnormality		
Endometriosis			Urinary Leakage		
Fibroid Uterus			Vaginal/Vulvar Infection		

Surgeries

Surgery	Yes	No	Date / Comments
Abdominal Surgery			
C-Section Delivery			
Dilation & Curettage (D & C)			
Hysterectomy			
Hysteroscopy (out patient)			
Laparoscopy (out patient)			
Vaginal Surgery			
Bartholin Glands Surgery			
Other (please specify)			

Social History

Preferred Name:	PCP:	Occupation:
Number of People in Household:	Single Married Widowed Divorced Separated Living w/Partner	
Education (last grade completed):	Name of significant other:	
Children's Names:		
Seat Belt Use: Always Frequently Occasionally Never		
How many days per week do you exercise?	How many packs of cigarettes per day do you smoke?	
How many times per week do you drink alcohol?		
Do you use any of the following? Cocaine Narcotics Marijuana Hallucinogens		

Family History – Please check all that apply

Illness	Mother	Father	Sibling	Child	Maternal GMother	Maternal GFather	Paternal GMother	Paternal GFather	Other (who)
Breast Cancer									
Colon Cancer									
Ovarian Cancer									
Alzheimer's Disease									
Birth Defects									
Blood Clots in lungs or legs									
Diabetes									
Drinking or Drug Problem									
Endometriosis									
Fibroids									
Heart Disease									
Hepatitis									
High Blood Pressure									
High Cholesterol									
HIV/AIDS									
Mental Illness/Depression									
Osteoporosis									
Stroke									
Tuberculosis									
Other									

Obstetric History

_____ # Total Pregnancies _____ # Miscarriages	_____ # Full Term _____ # Ectopic	_____ #Premature _____ # Multiples	_____ # Elective Abortions _____ # Living _____#Adopted

Pregnancy Details	#1	#2	#3	#4	#5	#6+
Pregnancy Outcome F = Full term, P = Premature, M = Miscarriage						
Delivery Date						
Weeks at Delivery						
Length of Labor (hrs)						
Epidural/Anesthesia						
Delivery Type V = Vaginal, C = C-Section						
Did you have Pre-term Labor?						
Delivery Location?						
Who delivered your baby?						
Baby weight?						
Baby Sex?						
Baby Name?						
Complications of Pregnancy	Please check all that apply					
Gestational Diabetes						
Macrosomia						
Multiple Gestation						
Post Dates						
Postpartum hemorrhage						
Pre-eclampsia						
Preterm Delivery						
Other Complication						

Established Annual Wellness Visit

Name: _____ Date: _____

Allergies: _____

Have you have the COVID-19 vaccine? _____ When? _____

1) Do you have any concerns that you want to talk to your provider about today (please explain)?

_____

_____

2) General gynecology update:
   - → First day of last menses (if you have menstrual cycles)? _____
     - days of bleeding? _____
     - how often menses occurs? _____
     - heavy bleeding? _____
     - bleeding irregularly or between menses? _____
   - → Current method of pregnancy prevention (if any)? _____
   - → Are you in a sexual relationship? Problems or concerns with sexual health? _____

   _____
   - → Wellness questions:
     - Do you have a primary care physician? Name and date of last visit. _____
     - Would you like to do wellness labs at your visit today? Y/N _____
     - If appropriate: When was your last mammogram? NA or _____
       When was your last colonoscopy? NA or _____
       When was your last bone density? NA or _____

3) Have you had any changes to your personal health, recent surgeries or change in family's health since your last visit at Athens OB/GYN? _____

   _____

4) Social update:
   - tobacco products (smoking, vaping, chewing)? _____
   - alcohol consumption (drinks per week)? _____
   - recreational drug use? _____
   - Exercise habits (activity and days a week) _____

5) Current medicines: (or provide list):

NAME	STRENGTH	INSTRUCTIONS FOR DOSING