

PEACHTREE WOMEN'S SPECIALISTS

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This form is intended to help us review your entire medical history as well as your present problem, if any exists. It will be a permanent part of your medical record and will be kept confidential. Please take a few moments and fill it out as completely as you can. Check each question that applies to you and put a question mark (?) if uncertain. If you have any questions or need help, do not hesitate to ask.

Please complete all four pages.
(Sometimes this is printed front and back.)

Name _____ **Date:** _____

Main reason for seeking medical attention: _____
() No complaint. Desire a periodic examination.

GENERAL INFORMATION:

Yes No
() () Have you had any x-rays taken in the past 5 years? Mammograms? _____ Date _____
List: _____

() () Have you ever had a blood transfusion?

() () Have you ever had any reaction or side effects from drugs, vaccines or other agents?
Aspirin or Pain Medicine (), Penicillin (), Sulfa (), Novocaine (),
Birth Control Pills (), Codeine ().
Other: () _____

() () Are you currently using some form of contraception?
Present method: _____ Date started: _____

() () Are you satisfied with present method?

() () Have you had a Pap (cancer) Smear in the past year? Date of last Pap smear: _____

() () Have you ever had an abnormal Pap smear? Date of Abnormal Pap: _____

Treatment: _____

GYNECOLOGIC HISTORY

MENSTRUAL HISTORY:

Age at first period? _____ Date of last normal menstrual period? _____

When not on birth control pills, are your periods: regular (), irregular ().

The interval between first day of one period to first day of next period ranges from ____ to ____ days.

Menstrual flow usually lasts for a total of _____ days.

Menstrual flow is usually: scant (), moderate (), heavy (), excessive with clots ().

- | | <u>Yes</u> | <u>No</u> |
|---|------------|-----------|
| Are your periods usually painful? | () | () |
| If painful: mild (), moderate (), severe (), incapacitating (). | | |
| Do you ever have bleeding or spotting between periods or following intercourse? | () | () |
| Do you currently have a problem with vaginal discharge, irritation or itching? | () | () |
| Do you frequently have loss of urine with sneezing or coughing? | () | () |
| Do you frequently have a sudden urgent need to urinate?..... | () | () |
| Do you have frequent night urination or bedwetting?..... | () | () |
| Do you have painful urination or difficulty in starting urination? | () | () |
| Do you ever have a bulging sensation from your vagina? | () | () |

OBSTETRIC HISTORY (if applicable)

How many babies born full term (more than 5 ½ lbs.)? _____

How many premature (less than 5 ½ lbs) born alive? _____

How many miscarriages or abortions? _____ Stillborn _____

How many living children do you have? _____ Year oldest born: _____ Year youngest born: _____

How many of your children have been born by Cesarean section? _____

Have all your children been normal? Yes (), No ().

Have you had any serious complication with any pregnancy? Explain:

PERSONAL HISTORY INFECTIOUS DISEASE: Check any of the following diseases you have had.

- | | | |
|------------------------------|---------------------------------|-----------------------------------|
| () Measles | () Hepatitis | () Herpes |
| () German Measles (Rubella) | () Pneumonia | () Chlamydia |
| () Mumps | () Encephalitis | () Condyloma, HPV, Genital Warts |
| () Polio | () Meningitis | () Syphilis |
| () Rheumatic Fever | () Infection on Tubes (PID) | () Gonorrhea |
| () Scarlet Fever | () Bladder or Kidney infection | () Other _____ |
| () Tuberculosis | () Abscess or boils | |
| () HIV | () Seizures, Epilepsy | |

SURGERY: Have you had an operation on any of the following?

	Year		Year
<input type="checkbox"/> Appendix	_____	<input type="checkbox"/> Hemorrhoids	_____
<input type="checkbox"/> Gall Bladder	_____	<input type="checkbox"/> Chest	_____
<input type="checkbox"/> Kidney	_____	<input type="checkbox"/> Ovary	_____
<input type="checkbox"/> Tonsils	_____	<input type="checkbox"/> Tubes	_____
<input type="checkbox"/> Thyroid	_____	<input type="checkbox"/> Uterus (Womb)	_____
<input type="checkbox"/> Breast	_____	<input type="checkbox"/> Vagina	_____
<input type="checkbox"/> Tumor of any kind	_____	<input type="checkbox"/> Bladder	_____
<input type="checkbox"/> Varicose Veins	_____	<input type="checkbox"/> Cesarean section	_____
<input type="checkbox"/> Hernia	_____	<input type="checkbox"/> D and C	_____

Others: _____

ILLNESSES: Have you ever had?

<input type="checkbox"/> Anemia	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Bone disease
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Back trouble
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Gall Bladder trouble	<input type="checkbox"/> Asthma or Hay fever
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chronic Diarrhea	<input type="checkbox"/> Convulsion
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hernia	<input type="checkbox"/> Kidney Stone
<input type="checkbox"/> Migraine	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Nervous breakdown
<input type="checkbox"/> Blood clots or phlebitis	<input type="checkbox"/> Colitis	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Skin disease

Others: _____

Have you ever been hospitalized for any other non-surgical illness? Yes () No ()

Diagnosis and year:

MEDICATIONS: Check any of the following medications you are presently taking or have taken in the past year.

<input type="checkbox"/> Cortisone or steroids	<input type="checkbox"/> Hormone pill or "shots"
<input type="checkbox"/> Blood pressure pills	<input type="checkbox"/> Sleeping pill
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Asthma medicine
<input type="checkbox"/> Heart medicine	<input type="checkbox"/> Arthritis medicine
<input type="checkbox"/> Diuretic (water) pills	<input type="checkbox"/> Tranquilizer or nerve pills
<input type="checkbox"/> Diet pills	

Others: _____

SOCIAL HISTORY:

Married? Yes () No () If yes, how long? _____

How long have you lived in Atlanta? _____ Do you exercise? Yes () No ()

Do you smoke? Yes () No () How much? _____ Alcohol? Yes () No () How much? _____

Education: _____ years High School; _____ years College; _____ years Graduate School

Patient: Age _____ Weight _____ Height _____ Health _____

Husband: Age _____ Weight _____ Height _____ Health _____

FAMILY HISTORY	If Living:		If Deceased:		Has Any Blood Relative Ever Had:		
	Age	Health	Age at Death	Cause	Please Check:		Who?
Father					Diabetes		
Mother					Tuberculosis		
					Cancer		
Brother or					DES Exposure		
Sister					Epilepsy		
1-					High Blood Pressure		
2-					Glaucoma		
3-					Birth Defects		
4-					Twins		
5-					Genetic Disorders:		
					(Husband's family or yours)		
Son or					Down's Syndrome		
Daughter					Tay-Sach's		
1-					Sickle Cell		
2-					Cystic Fibrosis		
3-					Cystic Kidneys		
4-					Hemophilia		
5-					Muscular Dystrophy		
					Thalassemia		
					Phenylketonuria		
					Seizures		
					Neural Tube Defect		
					Spina bifida		

SYSTEMS REVIEW: check any of the following symptoms that you have now or that have been present during the past six months.

- | | |
|--|---|
| <input type="checkbox"/> Any serious disease of the eyes, ears, nose, throat | <input type="checkbox"/> Loss or gain of 10 lbs. Or more in past six months |
| <input type="checkbox"/> Loss of consciousness, fainting, seizures | <input type="checkbox"/> Nausea or vomiting |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Blood or mucus in stool |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Black or tarry stool |
| <input type="checkbox"/> Rapid or irregular heartbeat | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Lumps in breast | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Breast discharge or change in size | <input type="checkbox"/> Leg cramps |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Persistent anxiety |
| <input type="checkbox"/> Chills, fever | |