



Peachtree City Obstetrics & Gynecology, P.C.

FOR OFFICE USE ONLY

NEW PATIENT

ESTABLISHED PATIENT

CONSULTATION

REPORT SENT: / /

OB/GYN COMPREHENSIVE PATIENT INTAKE HISTORY

PATIENT NAME:	AGE:	BIRTHDATE / /	DATE: / /
RACE: <input type="checkbox"/> CAUCASIAN <input type="checkbox"/> AFRICAN-AMERICAN <input type="checkbox"/> OTHER			
REFERRED BY:			PCP:
WHY HAVE YOU COME TO THE OFFICE TODAY?			
IS THIS A NEW PROBLEM?			
PLEASE DESCRIBE YOUR PROBLEM, INCLUDING WHERE IT IS, HOW SEVERE IT IS AND HOW LONG IT HAS LASTED.			

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your Provider.

				PROVIDER NOTES
LAST NORMAL MENSTRUAL PERIOD (FIRST DAY) / /				
AGE PERIODS BEGAN:				
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING)				
NUMBER OF DAYS BETWEEN PERIODS:				
ANY RECENT CHANGES IN PERIOD?				
ARE YOU CURRENTLY SEXUALLY ACTIVE?				
HAVE YOU EVER HAD SEX?				
NUMBER OF SEXUAL PARTNERS (LIFETIME)				
PRESENT METHOD OF BIRTH CONTROL				
HAVE YOU EVER USED:	YES	NO	IF YES, HOW LONG?	
INTRAUTERINE DEVICE (IUD)	<input type="checkbox"/>	<input type="checkbox"/>		
BIRTH CONTROL PILLS	<input type="checkbox"/>	<input type="checkbox"/>		
DEPO PROVERA	<input type="checkbox"/>	<input type="checkbox"/>		
VAGINAL RING	<input type="checkbox"/>	<input type="checkbox"/>		
PATCH	<input type="checkbox"/>	<input type="checkbox"/>		
IMPLANON	<input type="checkbox"/>	<input type="checkbox"/>		
WHEN WAS YOUR LAST PAP TEST?				
WHAT WAS THE RESULT?				
HAVE YOUR EVER HAD AN ABNORMAL PAP TEST? <input type="checkbox"/> Yes <input type="checkbox"/> No				
HAVE YOU BEEN EXPOSED TO DIETHYLSTILBESTROL? (DES) <input type="checkbox"/> Yes <input type="checkbox"/> No				
DO YOU DO BREAST SELF-EXAMINATIONS? <input type="checkbox"/> Yes <input type="checkbox"/> No				
WHEN WAS YOUR LAST MAMMOGRAM? (DATE) _____				
WHEN WAS YOUR LAST COLORECTAL SCREEN? (DATE) _____				
WHEN WAS YOUR LAST BONE DENSITY SCAN? (DATE) _____				

COMPREHENSIVE PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:	BIRTHDATE: / /	DATE: / /
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OBSTETRIC HISTORY

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS (<37 WEEKS)		LIVE BIRTHS		LIVING CHILDREN	
ANY PREGNANCY COMPLICATIONS?					
<input type="checkbox"/> DIABETES <input type="checkbox"/> HYPERTENSION/HIGH BLOOD PRESSURE <input type="checkbox"/> PREECLAMPSIA/TOXEMIA <input type="checkbox"/> OTHER					
ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? <input type="checkbox"/> NO <input type="checkbox"/> YES, HOW TREATED					

CURRENT MEDICATIONS
(Including hormones, vitamins, herbs, nonprescription medications)

DRUG NAME AND DOSAGE	WHO PRESCRIBED	DRUG NAME AND DOSAGE	WHO PRESCRIBED

FAMILY HISTORY

MOTHER <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED-CAUSE	AGE:	FATHER <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED-CAUSE	AGE:
SIBLINGS: NUMBER LIVING:	NUMBER DECEASED:	CAUSE(S)/AGES:	
CHILDREN: NUMBER LIVING:	NUMBER DECEASED:	CAUSE(S)/AGES:	
ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET	PROVIDER NOTES
DIABETES	<input type="checkbox"/>		
STROKE	<input type="checkbox"/>		
HEART DISEASE	<input type="checkbox"/>		
BLOOD CLOTS IN LUNGS OR LEGS	<input type="checkbox"/>		
HIGH BLOOD PRESSURE	<input type="checkbox"/>		
HIGH CHOLESTEROL	<input type="checkbox"/>		
OSTEOPOROSIS (WEAK BONES)	<input type="checkbox"/>		
HEPATITIS	<input type="checkbox"/>		
HIV/AIDS	<input type="checkbox"/>		
TUBERCULOSIS	<input type="checkbox"/>		
BIRTH DEFECTS	<input type="checkbox"/>		
ALCOHOL OR DRUG PROBLEMS	<input type="checkbox"/>		
BREAST CANCER	<input type="checkbox"/>		
COLON CANCER	<input type="checkbox"/>		
UTERINE CANCER	<input type="checkbox"/>		
MENTAL ILLNESS/DEPRESSION	<input type="checkbox"/>		
ALZHEIMER'S DISEASE	<input type="checkbox"/>		
OTHER	<input type="checkbox"/>		

COMPREHENSIVE PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:	BIRTHDATE: / /	DATE: / /
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SOCIAL HISTORY

	YES	NO	PROVIDER NOTES
EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:	<input type="checkbox"/>	<input type="checkbox"/>	
ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK: TYPE OF DRINK:	<input type="checkbox"/>	<input type="checkbox"/>	
DRUG USE	<input type="checkbox"/>	<input type="checkbox"/>	
SEAT BELT USE	<input type="checkbox"/>	<input type="checkbox"/>	
REGULAR EXERCISE: HOW LONG AND HOW OFTEN?	<input type="checkbox"/>	<input type="checkbox"/>	
DAIRY PRODUCT INTAKE AND/OR CALCIUM SUPPLEMENTS: DAILY INTAKE:	<input type="checkbox"/>	<input type="checkbox"/>	
HEALTH HAZARDS AT HOME OR WORK?	<input type="checkbox"/>	<input type="checkbox"/>	
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE?	<input type="checkbox"/>	<input type="checkbox"/>	
DO YOU HAVE AN ADVANCED DIRECTIVE (LIVING WILL)?	<input type="checkbox"/>	<input type="checkbox"/>	
ARE YOU AN ORGAN DONOR?	<input type="checkbox"/>	<input type="checkbox"/>	

PERSONAL PROFILE

SEXUAL ORIENTATION: <input type="checkbox"/> MEN <input type="checkbox"/> WOMEN <input type="checkbox"/> BOTH
MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> LIVING WITH PARTNER <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
NUMBER OF LIVING CHILDREN:
NUMBER OF PEOPLE IN HOUSEHOLD:
SCHOOL COMPLETED: <input type="checkbox"/> HIGH SCHOOL <input type="checkbox"/> SOME COLLEGE/AA DEGREE <input type="checkbox"/> COLLEGE <input type="checkbox"/> GRADUATE DEGREE <input type="checkbox"/> OTHER
CURRENT OR MOST RECENT JOB:
TRAVEL OUTSIDE THE UNITED STATES?

PERSONAL PAST HISTORY OF ILLNESS

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PROVIDER NOTES
ASTHMA		<input type="checkbox"/>	<input type="checkbox"/>	
PNEUMONIA/LUNG DISEASE		<input type="checkbox"/>	<input type="checkbox"/>	
KIDNEY INFECTIONS/STONES		<input type="checkbox"/>	<input type="checkbox"/>	
TUBERCULOSIS		<input type="checkbox"/>	<input type="checkbox"/>	
FIBROIDS		<input type="checkbox"/>	<input type="checkbox"/>	
SEXUALLY TRANSMITTED DISEASE/CHLAMYDIA		<input type="checkbox"/>	<input type="checkbox"/>	
INFERTILITY		<input type="checkbox"/>	<input type="checkbox"/>	
HIV/AIDS		<input type="checkbox"/>	<input type="checkbox"/>	
HEART ATTACK/DISEASE		<input type="checkbox"/>	<input type="checkbox"/>	
DIABETES		<input type="checkbox"/>	<input type="checkbox"/>	
HIGH BLOOD PRESSURE		<input type="checkbox"/>	<input type="checkbox"/>	
STROKE		<input type="checkbox"/>	<input type="checkbox"/>	
RHEUMATIC FEVER		<input type="checkbox"/>	<input type="checkbox"/>	
BLOOD CLOTS IN LUNGS OR LEGS		<input type="checkbox"/>	<input type="checkbox"/>	
EATING DISORDERS		<input type="checkbox"/>	<input type="checkbox"/>	
AUTOIMMUNE DISEASE (LUPUS)		<input type="checkbox"/>	<input type="checkbox"/>	
CHICKENPOX		<input type="checkbox"/>	<input type="checkbox"/>	
CANCER		<input type="checkbox"/>	<input type="checkbox"/>	
REFLUX/HIATAL HERNIA/ULCERS		<input type="checkbox"/>	<input type="checkbox"/>	
DEPRESSION/ANXIETY		<input type="checkbox"/>	<input type="checkbox"/>	
ANEMIA		<input type="checkbox"/>	<input type="checkbox"/>	
BLOOD TRANSFUSIONS		<input type="checkbox"/>	<input type="checkbox"/>	
SEIZURES/CONVULSIONS/EPILEPSY		<input type="checkbox"/>	<input type="checkbox"/>	
BOWEL PROBLEMS		<input type="checkbox"/>	<input type="checkbox"/>	
GLAUCOMA		<input type="checkbox"/>	<input type="checkbox"/>	
CATARACTS		<input type="checkbox"/>	<input type="checkbox"/>	
ARTHRITIS/JOINT PAIN/BACK PROBLEMS		<input type="checkbox"/>	<input type="checkbox"/>	
BROKEN BONES		<input type="checkbox"/>	<input type="checkbox"/>	
OSTEOPENIA/OSTEOPOROSIS		<input type="checkbox"/>	<input type="checkbox"/>	
HEPATITIS/YELLOW JAUNDICE/LIVER DISEASE		<input type="checkbox"/>	<input type="checkbox"/>	
THYROID DISEASE		<input type="checkbox"/>	<input type="checkbox"/>	

COMPREHENSIVE PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:

BIRTHDATE: / /

DATE: / /

PERSONAL PAST HISTORY OF ILLNESSES (Continued)

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PROVIDER NOTES
GALLBLADDER DISEASE				
HEADACHES				
DES EXPOSURE				
INFERTILITY				
BLEEDING DISORDERS				
OTHER				

OPERATIONS/HOSPITALIZATIONS

REASON	DATE	HOSPITAL
1.		
2.		
3.		
4.		
5.		

INJURIES/ILLNESS

TYPE	DATE	TYPE	DATE
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

IMMUNIZATIONS/TEST

	DATE		DATE
TETANUS-DIPHTERIA BOOSTER		INFLUENZA VACCINE (FLU SHOT)	
HEPATITIS A VACCINE		HEPATITIS B VACCINE	
VARICELLA (CHICKENPOX) VACCINE		PNEUMOCOCCAL (PNEUMONIA) VACCINE	
MEASLES-MUMPS-RUBELLA (MMR) VACCINE		TUBERCULOSIS (TB) SKIN TEST: RESULT:	
GARDASIL: #1 / / #2 / / #3 / /			

PROVIDER NOTES:

COMPREHENSIVE PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:

BIRTHDATE: / /

DATE: / /

REVIEW OF SYSTEMS

Please check (x) if any of the following symptoms apply to you now or since adulthood (Age 18)

	NOW	PAST	NOT SURE	PROVIDER NOTES
1. CONSTITUTIONAL				
WEIGHT LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
WEIGHT GAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FEVER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FATIGUE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHANGE IN HEIGHT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. EYES				
DOUBLE VISION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SPOTS BEFORE EYES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
VISION CHANGES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
GLASSES/CONTACTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. EAR, NOSE, AND THROAT				
EARACHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
RINGING IN EARS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HEARING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SINUS PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SORE THROAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MOUTH SORES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DENTAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. CARDIOVASCULAR				
CHEST PAIN OR PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DIFFICULTY BREATHING ON EXERTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SWELLING OF LEGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
RAPID OR IRREGULAR HEARTBEAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. RESPIRATORY				
PAINFUL BREATHING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
WHEEZING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SPITTING UP BLOOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHRONIC COUGH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. GASTROINTESTINAL				
FREQUENT DIARRHEA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BLOODY STOOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NAUSEA/VOMITING/INDIGESTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CONSTIPATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INVOLUNTARY LOSS OF GAS OR STOOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. GENITOURINARY				
BLOOD IN URINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PAIN WITH URINATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
STRONG URGENCY TO URINATE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FREQUENT URINATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INCOMPLETE EMPTYING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INVOLUNTARY - UNINTENDED URINE LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
URINE LOSS WHEN COUGHING/LIFTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ABNORMAL BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PAINFUL PERIODS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

COMPREHENSIVE PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:	BIRTHDATE: / /	DATE: / /
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REVIEW OF SYSTEMS (Continued)

	NOW	PAST	NOT SURE	PROVIDER NOTES
7. GENITOURINARY (Continued)				
PREMENSTRUAL SYNDROME (PMS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PAINFUL INTERCOURSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ABNORMAL VAGINAL DISCHARGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. MUSCULOSKELETAL				
MUSCLE WEAKNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MUSCLE OR JOINT PAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OSTEOPOROSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9a. SKIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
RASH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SORES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DRY SKIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MOLES (GROWTH OR CHANGES)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9b. BREASTS				
PAIN IN BREAST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NIPPLE DISCHARGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
LUMPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. NEUROLOGIC				
DIZZINESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NUMBNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TROUBLE WALKING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MEMORY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FREQUENT HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. PSYCHIATRIC				
DEPRESSION OR FREQUENT CRYING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ANXIETY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. ENDOCRINE				
HAIR LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HEAT/COLD INTOLERANCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ABNORMAL THIRST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HOT FLASHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. HEMATOLOGIC/LYMPHATIC				
FREQUENT BRUISES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CUTS DO NOT STOP BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ENLARGED LYMPH NODES (GLANDS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. ALLERGIC/IMMUNOLOGIC				
MEDICATION ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
IF ANY, PLEASE LIST ALLERGY AND TYPE OF REACTION				
LATEX ALLERGY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OTHER ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PLEASE LIST ALLERGY AND TYPE OF REACTION				

FORM COMPLETED BY <input type="checkbox"/> PATIENT <input type="checkbox"/> OFFICE NURSE <input type="checkbox"/> PROVIDER <input type="checkbox"/> OTHER	PAGE 6 OF 6
SIGNATURE OF PATIENT:	
DATE REVIEWED BY PROVIDER WITH PATIENT: / /	PROVIDER SIGNATURE:
ANNUAL REVIEW OF HISTORY: DATE REVIEWED: / / PROVIDER SIGNATURE:	DATE REVIEWED: / / PROVIDER SIGNATURE:
DATE REVIEWED: / / PROVIDER SIGNATURE:	DATE REVIEWED: / / PROVIDER SIGNATURE: