AZALEA WOMEN'S CENTER, P.C.

2307 NORTH PATTERSON, STREET, VLADOSTA, GA 31602

229-242-8888 (Phone) 229-242-0069 (faX)

GYNECOLOGIC HISTORY AND PHYSICAL

Name: ____Date Of Birth: ___________________Age: ______________

Date: _________________Drug Allergies: ____

Smoking Status: [ ] Current every day smoker [ ] Current some day smoker [ ] Former smoker [ ] Never smoker

PERSONAL HISTORY

MAJOR ILLNESSES	Yes	No		Yes	No		Yes	No
Asthma			Cancer			Weight Change		
Pneumonia			Ulcers			Fatigue		
Infectious Disease			Anemia/Blood Transfusions			Ent/ Mouth		
Kidney infections/Stones			Seizures/Epilepsy			Cardiovascular		
Tuberculosis			Bowel trouble			Respiratory		
Venereal Disease			Glaucoma			Gastrointestinal		
Heart trouble/Murmur			Arthritis/Joint pain			Genitourinary		
Diabetes			Fracture			Musculoskeletal		
High Blood Pressure			Hepatitis/Yellow Jaundice			Breast trouble		
Stroke			Thyroid Disease			Neurological		
STD			Urine Leakage			Psychiatric		
HIV			Endocrine			Hematologic/Lymphatic		
HSV 1			Allergies			Rheumatic Fever		
HSV 2								

OPERATIONS, HOSPITALIATIONS, INJURIES, AND ILLNESS

Reason	Date	Reason	Date

OB/GYN HISTORY

	Number		Number
Pregnacies		Abortions	
Miscarriages		Live Births	

CURRENT MEDICATIONS

Drug Name	Dosage	Drug Name	Dosage

FAMILY HISTORY

Illness	Yes	Relative	Illness	Yes	Relative
Diabetes			Alcohol Addiction		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		

SOCIAL HISTORY

	Yes	No		Yes	No
Alcohol			Drinks Per Day Drinks Per Week		
Drug Use					
Regular Exercise					

MENSTRUAL HISTORY

What was the first day of your last period? ____

At what age did you begin having periods? ____

Is the flow of your period heavy, medium, or light? ________________________Do you pass clots with your period? ___________

If you have heavy periods, how many pads/tampons do you soak in an hour? ____

Have you ever been treated for heavy periods? Yes [ ] No [ ] If yes, how and when? ____________________________________

____

How many days do you bleed with your period? ____

Do you bleed between periods? [ ] Yes [ ] No

Do you cramp with your periods? [ ] Yes [ ] No

How many days from the start of one period to the start of the next period? ____

Do you have vaginal itching or discharge between your periods: ____

Do you have pain during sex? [ ] Yes [ ] No

Do you bleed after sex? [ ] Yes [ ] No

When was your last pap smear? ___________________Have you had an abnormal pap smear? [ ]Yes [ ] No

When was your last mammogram? ____________________ Where was your last mammogram? ____________________________

When was your last bone density test? ____________________Where was your last bone density test? _____________________

Completed by: Patient [ ] Office staff [ ] Medical Provider [ ]

____________________________________ ___________________________

Patient Signature Date