DUNWOODY OBSTETRICS & GYNECOLOGY, P.C.
1829 INDEPENDENCE SQUARE, SUITE 1
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New Patient Questionnaire

Name:	Age:	Marital Status S M D W
Employer:	Position:	
Reason for Visit:		

PREVENTIVE HEALTH

	Date of Last:		Date of Last:		Date of Last:		Date of Last:
Colonoscopy		Gardasil		Flu Vaccine		Tetanus	
Pap Test		Mammogram		Rubella		Bone Density	

Was last pap: □ Normal □ Abnormal Any previous abnormal Pap date_____________ Treatment____________________

PAST MEDICAL HISTORY: please check (X) ALL areas that apply to you.

Vaginal Infections – History of: □ Yeast □ Trichomonas □ Chlamydia □ Herpes □ Gonorrhea

□ Arthritis	□ High Blood Pressure	□ Severe headaches
□ Asthma	□ Kidney/bladder problems	□ Skin disease
□ Anemia/blood disorder	□ Mitral valve prolapse	□ Stomach problems
□ Bowel disorders	□ Phlebitis	□ Thyroid disease
□ Diabetes	□ Seizures/epilepsy	□ Urinary incontinence
□ Hepatitis	□ Serious injuries	□ Other
□ Heart disease		

HOSPITAL ADMISSIONS or SURGERIES (excluding pregnancy)

Year	Description	Year	Description

Medication	Frequency of Dose	Medication	Frequency of Dose

DRUG ALLERGIES	REACTION	DRUG ALLERGIES	REACTION

FAMILY HISTORY: *Have any of your close relatives had any of the following conditions?*

Condition:	Relation to you	Maternal/Paternal	Diag. Age	Condition:	Relation to you	Maternal/Paternal	Diag. Age
□ Blood disorder				□ High blood pressure			
□ Breast cancer				□ Kidney disease			
□ Cancer				□ Lung disease			
□ Diabetes				□ Ovarian cancer			
□ Heart attack				□ Stroke			

In order to provide the highest quality care possible, please complete this form entirely on the front and the back. Thank you.

SOCIAL HISTORY

Smoking ◻ Yes ◻ No (#cigs. per day?) Alcohol ◻ Yes ◻ No _____ Drinks/Week Street drugs ◻ Yes ◻ No

Caffeine Tea/Coffee ______ cups/day Colas _________ cans/day

Exercise: ◻ None _____times per week Activity:

Sexual History: ◻ Satisfactory ◻ Uncomfortable ◻ Wish to discuss

MENSTRUAL HISTORY

Age at 1st period _____ Date of last period (1st day) ______________ Period Interval (1st day to 1st day) # of days_________

Cramps ◻ Yes ◻ No ◻ Mild ◻ Moderate ◻ Severe Medication for cramps ________________________________

Duration of bleeding _______ Menopausal Yes, I am ◻ Pre ◻ Post or No ◻ I have had a hysterectomy

Contraceptive History Current Method: Past Methods:

OBSTETRICAL HISTORY

Total Preg:_______ Full Term Births:_______ Premature Births_______ No. of Abortions Induced:_______

No. of Abortions: Spontaneous_______ Ectopic Births_______ Multiple Births (twins)_______ Living Children_______

Month/Day/Year	Weeks Preg.	Weight	Sex	Type of Delivery	Remarks
1)					
2)					
3)					
4)					
5)					
6)					

PLEASE CHECK (X) IF ANY OF THE FOLLOWING SYMPTOMS APPLY TO YOU ***CURRENTLY***

CONSTITUTIONAL
- ◻ Weight loss
- ◻ Weight gain
- ◻ Fever
- ◻ Fatigue

CARDIOVASCULAR
- ◻ Painful breathing
- ◻ Chest pain
- ◻ Difficulty breathing on exertion
- ◻ Swelling of legs
- ◻ Palpitations of heart

SKIN
- ◻ Rash
- ◻ Ulcers

EYES
- ◻ Double vision
- ◻ Spots before eyes
- ◻ Vision changes

RESPIRATORY
- ◻ Wheezing
- ◻ Spitting up blood
- ◻ Shortness of breath
- ◻ Cough, chronic

NEUROLOGIC
- ◻ Dizziness
- ◻ Seizures
- ◻ Numbness
- ◻ Trouble walking

EARS, NOSE, THROAT
- ◻ Ear aches
- ◻ Ringing in ears
- ◻ Sinus problems
- ◻ Sore throat
- ◻ Mouth sores
- ◻ Dental problems

GASTROINTESTINAL
- ◻ Frequent diarrhea
- ◻ Bloody stool
- ◻ Nausea/vomiting
- ◻ Constipation

MUSCULOSKELETAL
- ◻ Muscle weakness

BREASTS
- ◻ Pain in breast
- ◻ Discharge
- ◻ Masses
- ◻ Implants

GENITOURINARY
- ◻ Blood in urine
- ◻ Pain with urination
- ◻ Urgency
- ◻ Frequency of urination
- ◻ Incomplete emptying
- ◻ Stress incontinence
- ◻ Abnormal periods
- ◻ Painful intercourse

ENDOCRINE
- ◻ Dry skin
- ◻ Abnormal thirst
- ◻ Hot flashes

PSYCHIATRIC
- ◻ Depression
- ◻ Frequent crying

HEMATOLOGIC/LYMPHATIC
- ◻ Easy bruising
- ◻ Enlarged lymph nodes
- ◻ Easy bleeding