

Gynecology & Obstetrics of DeKalb P.C.

GYNECOLOGY/OBSTETRICAL HISTORY

2801 N. DECATUR RD., SUITE 190, DECATUR, GA 30033
 TELEPHONE (404) 299-9307 FACSIMILE 404) 299-9309

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 TELEPHONE (770) 469-9661 FACSIMILE (770) 413-0030

DATE _____

PATIENT _____ BIRTH DATE ____ / ____ / ____ PATIENT # _____

Welcome to our practice. Please help us meet all your healthcare needs by completing the shaded area below in ink. If you have any questions or need assistance, please ask us. We will be happy to help you!

ALLERGIES/DRUG REACTIONS

HABITS/ENVIRONMENTAL FACTORS

NO	YES				NO	YES	PLEASE LIST DRUGS USED
<input type="checkbox"/>	<input type="checkbox"/>	COFFEE/TEA _____ CUPS/DAY	1.	DO YOU EXERCISE REGULARLY?	<input type="checkbox"/>	<input type="checkbox"/>	TYPE _____ AMT/DAY _____
<input type="checkbox"/>	<input type="checkbox"/>	COLA, OTHER CAFFEINE DRINKS _____/DAY	2.	DO YOU USE A HOT TUB?	<input type="checkbox"/>	<input type="checkbox"/>	TYPE _____ AMT/DAY _____
<input type="checkbox"/>	<input type="checkbox"/>	CIGARETTES – NOW _____/DAY _____ YRS	3.	ARE YOU EVER AROUND CATS?	<input type="checkbox"/>	<input type="checkbox"/>	TYPE _____ AMT/DAY _____
<input type="checkbox"/>	<input type="checkbox"/>	PAST _____/DAY _____ YRS	4.	DO YOU, OR HAVE YOU, USED DRUGS? (MARIJUANA, COCAINE, UPPERS, DOWNERS, ETC)?	<input type="checkbox"/>	<input type="checkbox"/>	TYPE _____ AMT/DAY _____
<input type="checkbox"/>	<input type="checkbox"/>	ALCOHOL _____/DAY _____/WEEK					

PLEASE LIST CONTRACEPTIVES YOU HAVE USED:
 TYPE _____ DATES USED _____

PLEASE LIST ALL PRESCRIPTION DRUGS YOU CURRENTLY USE:
 DRUG _____ CONDITION _____ AMOUNT/DAY _____

PREGNANCY HISTORY			GRAVIDA	FULL TERM	PREMATURE	SPONTANEOUS AB	INDUCED AB	ECTOPIC	MULTIPLE BIRTHS	LIVING
NO	MONTH/ YEAR	INFANT SEX	BIRTH WEIGHT	WEEKS GEST	HOURS IN LABOR	TYPE OF DELIVERY	ANESTHESIA	DETAILS/COMPLICATIONS		
1										
2										
3										
4										
5										
6										

MENSTRUAL HISTORY

ONSET _____ AGE _____

LENGTH _____ DAYS _____

CYCLE _____ DAYS _____

LMP APPROXIMATE NORMAL YES
 DEFINITE NO

POS. PREG. TEST DATE _____ BLOOD
 URINE

LMP _____

ULTRA SOUND _____

FINAL EDD _____

GYNECOLOGICAL / OBSTETRICAL HISTORY

PATIENT # _____

MEDICAL HISTORY

OBSTETRIC

	PATIENT		FAMILY	
	NO	YES	NO	YES
1. FETAL/NEONATAL DEATH OR ANOMALY.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. INTRAUTERINE GROWTH RETARDATION.....	<input type="checkbox"/>	<input type="checkbox"/>		
3. PRETERM LABOR OR BIRTH.....	<input type="checkbox"/>	<input type="checkbox"/>		
4. GESTATIONAL DIABETES.....	<input type="checkbox"/>	<input type="checkbox"/>		
5. PREGNANCY- INDUCED HYPERTENSION.....	<input type="checkbox"/>	<input type="checkbox"/>		
6. ANEMIA.....	<input type="checkbox"/>	<input type="checkbox"/>		
7. HEMORRHAGE.....	<input type="checkbox"/>	<input type="checkbox"/>		
8. HYPEREMESIS.....	<input type="checkbox"/>	<input type="checkbox"/>		
9. INCOMPETENT CERVIX.....	<input type="checkbox"/>	<input type="checkbox"/>		
10. POLYDRAMNIOS.....	<input type="checkbox"/>	<input type="checkbox"/>		
11. ISOIMMUNIZATION.....	<input type="checkbox"/>	<input type="checkbox"/>		
12. PROM-CHORIOAMNIONITIS.....	<input type="checkbox"/>	<input type="checkbox"/>		
13. RH NEG.....	<input type="checkbox"/>	<input type="checkbox"/>		
14. RHOGAM GIVEN.....	<input type="checkbox"/>	<input type="checkbox"/>		
15. POSTPARTUM DEPRESSION.....	<input type="checkbox"/>	<input type="checkbox"/>		
16. OTHER.....	<input type="checkbox"/>	<input type="checkbox"/>		

GYNECOLOGIC

17. ABNORMAL PAP.....	<input type="checkbox"/>	<input type="checkbox"/>		
18. UTERINE ANOMALY.....	<input type="checkbox"/>	<input type="checkbox"/>		
19. IN UTERO EXPOSURE TO DES.....	<input type="checkbox"/>	<input type="checkbox"/>		
20. INFERTILITY.....	<input type="checkbox"/>	<input type="checkbox"/>		
21. GYN SURGERY.....	<input type="checkbox"/>	<input type="checkbox"/>		
22. OTHER.....	<input type="checkbox"/>	<input type="checkbox"/>		

ENDOCRINE

23. ENDOCRINOPATHY.....	<input type="checkbox"/>	<input type="checkbox"/>		
24. THYROID DYSFUNCTION.....	<input type="checkbox"/>	<input type="checkbox"/>		
25. DIABETES.....	<input type="checkbox"/>	<input type="checkbox"/>		
26. MATERNAL PKU.....	<input type="checkbox"/>	<input type="checkbox"/>		
27. GASTROINTESTINAL.....	<input type="checkbox"/>	<input type="checkbox"/>		
28. LIVER DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>		
29. OTHER.....	<input type="checkbox"/>	<input type="checkbox"/>		

DETAIL AND REFERENCE POSITIVE FINDINGS BELOW:

CARDIOVASCULAR

	PATIENT		FAMILY	
	NO	YES	NO	YES
30. HEART DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. VALVE DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. BLOOD TRANSFUSIONS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. BLOOD CLOTS.....	<input type="checkbox"/>	<input type="checkbox"/>		
34. VARICOSE VEINS.....	<input type="checkbox"/>	<input type="checkbox"/>		
35. RHEUMATIC FEVER.....	<input type="checkbox"/>	<input type="checkbox"/>		
36. CHRONIC HYPERTENSION.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. BLOOD DISORDERS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. OTHER.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PULMONARY

39. ASTHMA.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. TUBERCULOSIS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. CHRONIC OBSTRUCTIVE PULMONARY DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. OTHER.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RENAL DISEASE

43. ASYMPTOMATIC BACTERIURIA.....	<input type="checkbox"/>	<input type="checkbox"/>		
44. PYELOPHRITIS.....	<input type="checkbox"/>	<input type="checkbox"/>		
45. CYSTITIS.....	<input type="checkbox"/>	<input type="checkbox"/>		
46. CHRONIC RENAL DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. OTHER.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OTHER

48. AUTOIMMUNE DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. CANCER.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. CONVULSIVE DISORDERS – EPILEPSY.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. NERVOUS MENTAL DISORDERS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52. NEUROLOGIC/SEIZURE DISORDER.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53. PSYCHIATRIC DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54. HOSPITALIZATION; SURGERY OR INJURY.....	<input type="checkbox"/>	<input type="checkbox"/>		

INFECTION HISTORY

	PATIENT		FAMILY	
	NO	YES	NO	YES
55. AIDS (HIV).....				
56. TB OR TB EXPOSURE.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57. HEPATITIS (TYPE _____).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
58. GENITAL HERPES.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
59. CHLAMYDIA.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
60. GONORRHEA.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
61. SYPHILIS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	PATIENT	
	NO	YES
62. TRICHOMONAS.....		
63. CONDYLOMATA.....	<input type="checkbox"/>	<input type="checkbox"/>
64. TOXOPLASMOSIS.....	<input type="checkbox"/>	<input type="checkbox"/>
65. CHICKEN POX.....	<input type="checkbox"/>	<input type="checkbox"/>
66. RUBELLA.....	<input type="checkbox"/>	<input type="checkbox"/>
67. CYTOMEGALO VIRUS (CMV).....	<input type="checkbox"/>	<input type="checkbox"/>
68. OTHER.....	<input type="checkbox"/>	<input type="checkbox"/>

GENETIC HISTORY

	PATIENT		
	BABY'S FATHER	FAMILY	
70. AGE ≥35 (♂) ≥50 (♀).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
71. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ORIENTAL BACKGROUND).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
72. TAY-SACHS DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
73. CYSTIC FIBROSIS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
74. DOWN'S SYNDROME.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75. CEREBRAL PALSY.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
76. HEMOPHILIA.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
77. MUSCULAR DYSTROPHY.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	PATIENT		
	BABY'S FATHER	FAMILY	
78. SICKLE CELL DISEASE OR TRAIT.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
79. NEUTRAL TUBE DEFECT.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
80. HUNTINGTON'S CHOREA.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
81. CONGENITAL ANOMALIES.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
82. TEST FOR FRAGILE X.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
83. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
84. OTHER.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature _____

Date _____

Physician/NP Signature _____

Date _____

Reviewed: Date _____ Pt Initials _____ MD/NP Initials _____

Reviewed: Date _____ Pt Initials _____ MD/NP Initials _____

Reviewed: Date _____ Pt Initials _____ MD/NP Initials _____