EVALUATION **Atlanta GYN Associates, P.C.**

Your Name: _____
Your Date of Birth: _____ Age: _____
Today's Date: _____

Has your insurance information changed since your last visit?
(circle) Yes No (If yes, please give new card to receptionist.)

Please list or circle problems you are having:

Menopause	Pelvic pain	Birth Control Issues
Abnormal bleeding	Irregular periods	Vaginal discharge

Please describe why you are here today, and list any problems you have been experiencing or concerns you have:

Last Menstrual Period?
Date: _____
Normal? (circle) Yes No
Usual length: _____ days
Usual frequency: _____ days
Problems (circle) Yes No
Number of pads/tampons per day:
Clots: (circle) Yes No Size: _____
Recent changes? _____

Contraception?
Methods:
Problems (circle) Yes No
Condom Use (circle) Yes No
Sexually active (circle) Yes No
Ever had sex (circle) Yes No

Hormones? Name/Dosage/Schedule
_____
_____
_____
_____
Problems (circle) Yes No
If yes, describe:

Present Health Status:
Since your last annual exam:
Who is your internist/family physician? _____

Any new medical problems (circle) Yes No
If yes, describe: _____

Any new surgical procedures (circle) Yes No
If yes, date/describe: _____

Drug Allergies (list): _____
Latex Allergy? Yes No

Present Medications (list with dosage):
Include over the counter, vitamins and herbal supplements _____ _____ _____ _____ _____ _____

If you are taking more than 2 medications, we recommend these be typed and brought to all of your appointments.

Any new major illnesses in your family (circle) Yes No
If yes, describe: _____

Circle any areas where you have problems or concerns and describe:
Heart Lungs Kidneys Headaches Stomach/GI tract

THE BEST PHONE NUMBER TO REACH ME/LEAVE A PRIVATE MEDICAL MESSAGE IS: _____
If your address has changed, please notify receptionist.

☐ Reviewed