



MEDICAL HISTORY Page 2

Your Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Your Medical History:

Circle/Check any that apply

List any names of doctors

- \_\_\_ Allergies
- \_\_\_ Arthritis/Osteoporosis
- \_\_\_ Baby weighing more than 9 lbs.
- \_\_\_ Blood clots/phlebitis
- \_\_\_ Body jewelry Location \_\_\_\_\_
- \_\_\_ Bowel problems/Ulcers/Diarrhea/Constipation
- \_\_\_ Broken/fractured bone
- \_\_\_ Depression/Psychological Problems
- \_\_\_ Diabetes/Thyroid Disease
- \_\_\_ Emphysema/Asthma/Pneumonia
- \_\_\_ Heart Disease/Mitral Valve Prolapse/Hypertension
- \_\_\_ Hepatitis/Jaundice/Gallbladder Disease
- \_\_\_ HIV Infection or exposure
- \_\_\_ Migraines/Headaches/Seizures
- \_\_\_ Alcohol Use: \_\_\_\_\_ oz. per week
- \_\_\_ Street Drugs: Type: \_\_\_\_\_
- \_\_\_ Tattoos # \_\_\_\_\_ location \_\_\_\_\_
- \_\_\_ Tobacco Use: \_\_\_\_\_ per day for \_\_\_\_\_ years  
stopped smoking \_\_\_\_\_ years ago
- \_\_\_ Refuse Blood Products for Religious Reasons
- \_\_\_ Other Concerns: (circle and describe)  
Heart Lungs Kidney Joints Gastrointestinal

Your Family's Medical History:

Circle/Check any that apply

- \_\_\_ Anesthetic Problems
- \_\_\_ Bleeding Problems
- \_\_\_ Blood clots in legs or lungs
- \_\_\_ Breast Cancer
- \_\_\_ Colon Cancer
- \_\_\_ Ovarian Cancer
- \_\_\_ Diabetes
- \_\_\_ Elevated Cholesterol
- \_\_\_ Genetic Problems
- \_\_\_ Heart Disease/Heart Attack
- \_\_\_ Hepatitis/Other liver disease
- \_\_\_ High Blood Pressure
- \_\_\_ Kidney Disease
- \_\_\_ Lung Disease
- \_\_\_ Osteoporosis/hip fracture
- \_\_\_ Puberty/Growth Disorders
- \_\_\_ Seizures
- \_\_\_ Skin Cancer
- \_\_\_ Stroke
- \_\_\_ Thyroid
- \_\_\_ Unknown/Adopted
- \_\_\_ Other: \_\_\_\_\_

Calcium intake/day

- \_\_\_ servings dairy/day
- \_\_\_ mg in multivitamin
- \_\_\_ Calcium tablets each \_\_\_mg
- \_\_\_\_\_
- \_\_\_ Total mg/day Calcium

Vitamin D intake/day

- \_\_\_ min sunshine/day
- \_\_\_ units vitamin D over the counter/day
- \_\_\_ units prescription vit D \_\_\_/week
- \_\_\_ units vitamin D with calcium \_\_\_ tabs/day
- \_\_\_\_\_
- \_\_\_ Total vitamin D units/day

Specify for these:

- Relationship/Age of diagnosis - example: mother/48
- m=mother f=father
- mgm=maternal grandmother s=sister
- mgf=maternal grandfather mu=maternal uncle
- ma=maternal aunt pa=paternal aunt
- pgm=paternal grandmother pu=paternal uncle
- pgf=paternal grandfather

Prior Surgery: List type of surgery (Include date, hospital and doctor.)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Other Hospitalizations:

(Include date, hospital reason for admission and doctor.)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Allergies/Drug Reactions:

(Describe reaction/include latex allergy)

Medications: Put a star by the ones we prescribe and indicate 3- or 1-month prescription (Ex: Estrace 1 mg (3)). If you take more than 2 medications, type the list on your computer and bring to your office visits and carry a copy in your wallet. (Prescription/over the counter/herbal/nutritional supplements. Please include dose and schedule).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL HISTORY** Page 3

Your Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Health Care Maintenance**

**PLEASE COMPLETE EACH BOX BELOW**  
(for example, cholesterol 2000 normal)

	Date/Results:	Recommendations:	Check If Desired:	Available at AGA
Pap		Yearly or per provider		*
Mammogram		Baseline 35–40/Every 1–2 years 40–50 Years/50 and yearly		
Screening for Sexually Transmitted Diseases such as Chlamydia, Gonorrhea		Yearly under 25 or as needed		*
**HIV Screen, Syphilis screen, Hepatitis A, B and C screen		As needed		*
Cholesterol / Lipid Profile		Every 5 years, sooner if abnormal		*
Thyroid Blood Tests		Every 5 years after 40		*
Colonoscopy (Scope to examine colon for polyps/cancer)		Screening at 50, then every 5-10 years if African-American		
Bone Density Test QUS (heel ultrasound) **DEXA (x-ray test hip and spine)		Menopause or other risk factors begin @ 45 Depo-Provera use Eating disorder Low calcium intake		*
<i>Those immunizations not available at AGA may be available at Pediatrician, Family Practice, Internal Medicine office or Health Department</i>				
Immunizations:	Diphtheria, Pertussis, Tetanus		Every 10 years	*
	Measles, Mumps, Rubella		If born 1957 or later, 2nd dose after childhood	
	Hepatitis B, Hepatitis A		Teens, Young Adults	*
	Meningitis		Teens, Young Adults	
	HPV (Gardasil)		Teens, Young Adults under 27 years	*
	Pneumovax		65 and older every 5 years	
	Zostovax (Shingles Vaccine)		60 and older	

\*\*Please check with your insurance company before your visit to see if they cover these particular tests. They may be less expensive at Any Lab or the Health Department.

Who is your internist/family physician? \_\_\_\_\_

Would you like a referral? No Yes (Please provide us with a list of doctors on your plan)

**Did you know? \* Condoms save lives!**

- People who exercise live longer. You are what you eat. We recommend a low fat, lower carbohydrate diet.
- Sunscreen use helps prevent skin cancer.
- Seat belts save lives! (Car accidents are the number 1 cause of death in females 13–39 years of age.)
- Most girls/women do not get enough calcium. Most need 1000–1500 mg a day!
- Smoking causes wrinkles, osteoporosis, low birth weight babies, emphysema and lung cancer.  
You can quit! We can help!
- No woman ever deserves to be battered. If you do not feel safe, we can help! Tell us!!

I voluntarily give my consent for Atlanta GYN Associates, PC physicians (or any medical personnel under their supervision) to provide office gynecological care, including examinations, diagnostic testing (e.g., blood, urine, and ultrasound) and injections. This authorization remains in effect until I notify the office in writing that I no longer wish to receive care from this practice.

**I have received and reviewed a copy of AGA, PC's HIPPA's notice of privacy practices.**

**If under 18 years of age, complete:**

\_\_\_\_\_  
Signature of Patient Date

I, as custodial parent or legal guardian of \_\_\_\_\_, authorize examination and treatment of my child.

\_\_\_\_\_  
Signature Date

**THE BEST PHONE NUMBER TO REACH ME/LEAVE A PRIVATE MEDICAL MESSAGE IS:** \_\_\_\_\_

If your address has changed, please notify receptionist.

**PHARMACY #** \_\_\_\_\_