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

Your Name: _____

Your Date of Birth: _____ Age: _____

Today's Date: _____

This important information helps us provide you with the best of care!

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
Abnormal bleeding
Pelvic pain
Irregular periods
Birth Control Issues
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? _____

Do you smoke? _____ amount/week
Do you drink? _____ amount/week
Excercise? _____ amount/week

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

Calcium intake/day
___ servings dairy/day
___ mg in multivitamin
___ Calcium tablets each __ mg
_____
___ Total mg/day Calcium

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

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 0 units/day

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.

PHARMACY # _____

AGA036:9/10R

☐ Reviewed