

Castillo Walters OB/GYN

A Division of Atlanta Women's Health Group, P.C.

WELCOME TO OUR PRACTICE!

PLEASE ANSWER THE FOLLOWING QUESTIONS:

NAME: _____ **DOB:** _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

REFERRED BY : _____ REASON FOR TODAY'S VISIT: _____

DATE AND RESULTS OF YOUR LAST PAP SMEAR: _____

FIRST DATE OF YOUR LAST MENSTRUAL PERIOD: _____

NUMBER OF DAYS YOU HAVE BLEEDING WITH YOUR PERIOD : _____

HAS THERE RECENTLY BEEN A CHANGE IN THE NUMER OF DAYS BETWEEN YOUR PERIODS?

DO YOU BLEED HEAVILY WITH YOUR PERIODS ? Yes _____ No _____

DO YOU FEEL A LOT OF DISCOMFORT JUST BEFORE YOUR PERIOD? Yes _____ No _____

ARE YOU TAKING HORMONES? Yes _____ No _____

DO YOU TAKE ANY KIND OF MEDICINE ON A REGUALR BASIS? Yes _____ No _____

DOES SEXUAL INTERCOURSE CAUSE YOU PAIN ? Yes _____ No _____

DO YOU BLEED AFTER INTERCOURSE? Yes _____ No _____

ARE YOU HAVING A PROBLEM WITH VAGINAL DISCHARGE? Yes _____ No _____

DO YOU EVER LOSE URINE WHEN YOU COUGH OR SNEEZE? Yes _____ No _____

HAVE YOU BEEN HAVING A PROBLEM WITH DISCHARGE FROM YOUR BREAST? Yes ___ No ___

HAVE YOU EVER HAD A LUMP OR MASS IN YOUR BREAST? Yes _____ No _____

DO YOU EVER BLEED FROM YOUR RECTUM? Yes _____ No _____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? Yes _____ No _____

IS THERE A HISTORY OF BREAST CANCER IN YOUR FAMILY? Yes _____ No _____

DATE AND RESULTS OF YOUR LAST MAMMOGRAM : _____

DATE AND RESULTS OF YOUR LAST CHOLESTEROL LEVEL: _____

ANY HISTORY OF **DES** EXPOSURE FROM YOU OR YOUR MOTHER ? _____

DES (dyethylstilbestrol) is a man-made (synthetic) form of estrogen , a female hormone. Doctors prescribed it from 1938 until 1971 to help some pregnant women who had had miscarriages or premature deliveries in the past (for more information visit www.cancer.org)

Patient's initials _____ Date: _____

PERSONAL HISTORY

SURGERIES/MAJOR ILLNESSES/ACCIDENTS

LIST ANY OPERATIONS OR SURGICAL PROCEDURES YOU HAVE HAD:

OPERATIONS: _____ YEAR _____

OPERATIONS: _____ YEAR _____

LIST ANY SERIOUS ACCIDENTS (BROKEN BONES, ETC.) YOU HAVE HAD:

ACCIDENTS: _____ YEAR _____

LIST ALL OTHER SERIOUS ILLNESS YOU HAVE HAD:

ILLNESS: _____ YEAR _____

ILLNESS: _____ YEAR _____

BLOOD DONOR

HAVE YOU EVER BEEN REFUSED AS A BLOOD DONOR? YES ___ NO ___

IF YES, WHY? _____

MEDICATIONS

LIST ALL MEDICATIONS YOU ARE TAKING NOW, OR HAVE TAKEN IN THE PAST YEAR. INCLUDE ALL OVER-THE -COUNTER PREPARATIONS, SKIN CREAMS, ORAL CONTRACEPTIVES, VITAMINS AND MINERALS.

MEDICATION _____ DOSE _____

MEDICATION _____ DOSE _____

ALLERGIES

LIST ALL BAD REACTIONS, ALLERGIES, OR SENSITIVITIES TO MEDICATIONS:

MEDICATION _____ DOSE _____ TYPE OF REACTION _____

MEDICATION _____ DOSE _____ TYPE OF REACTION _____

GYNECOLOGY

ARE YOU PREGNANT? YES ___ NO ___

IF NOT, ARE YOU HAVING A MONTHLY MENSTRUAL PERIOD? YES ___ NO ___

HAVE YOU EVER HAD AN ABNORMAL MAMMOGRAM? YES ___ NO ___

LIST THE NUMBER OF CHILDREN YOU HAVE HAD: _____

LIST THE NUMBER OF ABORTIONS OR MISCARRIAGES YOU HAVE HAD: _____

Patient's initials _____ *Date:* _____

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GENERAL

LIST ANY HEALTH PROBLEMS NOT COVER IN THIS QUESTIONNAIRE:

ADULT HISTORY REVIEW:

OCUPATION: _____

FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	IF DECEASED, CAUSE OF DEATH AND AGE
SELF			
FATHER			
MOTHER			
BROTHERS			
SISTERS			
SPOUSE			
CHILDREN			

INDICATE WHICH BLOOD RELATIVES (PARENT, BROTHER/SISTER, GRANDPARENT, CHILD, AUNT/UNCLE) HAVE THE FOLLWING:

HIGH BLOOD PRESSURE _____ THYROID DISEASE/GOTTER _____

STROKE _____ ALCOHOLISM _____

HEART DISEASE _____ HIGH CHOLESTEROL _____

DIABETES _____ TRIGLYCERIDES _____

GLAUCOMA _____ OSTEOPOROSIS _____

CANCER(ANY TYPE) _____

ASTHMA,HIVES,ECZEMA,HAY FEVER _____

OTHER: _____

Patient's initials _____ *Date:* _____