SOUTH COBB OB-GYN
Confidential Health Questionnaire

NAME:_____ DATE OF BIRTH:____/____/____ TODAYS DATE:____/____/____

Employer / Occupation:_____

REASON FOR VISIT: ANNUAL EXAM ☐ PREGNANCY CARE ☐

PROBLEM EXAM (Please Specify)_____

CURRENT MEDICATIONS:

Drug Name	Dosage	Drug Name	Dosage

Drug Allergies:

GYN HISTORY

Last menstrual period (Date) ____/____/____	Date of last pap smear_____
Periods: Regular ☐ Irregular ☐	History of Abnormal pap smears? Yes ☐ No ☐
How far apart are your periods_____	Do you use any kind of birth control? Yes No
How many days are your periods_____	Type:_____How Long_____
Painful periods? Yes ☐ No ☐	Are you satisfied with this method? Yes ☐ No ☐
Are periods Light ☐ Moderate ☐ Heavy ☐	
Sexually Active Yes ☐ No ☐	
Painful Intercourse Yes ☐ No ☐	

REVIEW OF SYSTEMS

Please mark (x) if any of the following apply to you now, in the past or often

	Current	Past
CONSTITUTIONAL		
Weight Loss	☐	☐
Weight Gain	☐	☐
Fever	☐	☐
Fatigue	☐	☐
CARDIOVASCULAR		
Chest Pain	☐	☐
Swelling of Legs	☐	☐
Palpitations of Heart	☐	☐
RESPIRATORY		
Wheezing	☐	☐
Spitting up Blood	☐	☐
Shortness of Breath	☐	☐
GASTROINTESTINAL		
Diarrhea, frequent	☐	☐
Bloody Stool	☐	☐
Nausea / Vomiting	☐	☐
Constipation	☐	☐
BREAST		
Pain in Breast	☐	☐
Discharge	☐	☐
Masses	☐	☐

	Current	Past
URINARY		
Blood in Urine	☐	☐
Pain with Urination	☐	☐
Urgency	☐	☐
Frequency of Urination	☐	☐
Incomplete Emptying	☐	☐
Stress Incontinence	☐	☐
MUSCULOSKELETAL		
Muscle Weakness	☐	☐
ENDOCRINE		
Dry Skin	☐	☐
Abnormal Thirst	☐	☐
Hot Flashes	☐	☐
HEMATOLOGIC / LYMPHATIC		
Bruises, frequent	☐	☐
Cuts do not stop Bleeding	☐	☐
Enlarged Lymph Nodes	☐	☐
PSYCHIATRIC		
Depression	☐	☐
Crying, frequent	☐	☐

If you have checked any of the above, are you currently receiving treatment or evaluation for the condition(s)?

Patient Signature:_____ Provider Signature:_____Date:____/____/____

Please complete next page only if you are a New Patient or if todays visit is for your Yearly Exam, thank you.

South Cobb OB-Gyn

Confidential Health Questionnaire (Complete only for New Patients and Yearly Exams)

Name:_____ Date of Birth_____/_____/_____ Todays Date_____/_____/_____

OBSTETRICAL HISTORY	PREVIOUS SURGERY AND HOSPITILIZATIONS
Number of Pregnancies_____	DATE:_____REASON:_____
Number of Deliveries_____	DATE:_____REASON:_____
Number of Miscarriages_____	DATE:_____REASON:_____
Number of Terminations (Abortions)_____	**Date of last Mammogram:**_____
Number of Living Children_____	Date of Colonoscopy / Flex Sig:_____

PERSONAL PAST HISTORY (Major Illnesses)					
	Yes	**No**		**Yes**	**No**
Asthma			Cancer (Specify Type)		
Chronic Lung Disease			Ulcers		
Kidney Infections / Stones			Depression / Anxiety		
Tuberculosis			Anemia / Blood Transfusions		
Venereal Disease			Seizures / Convulsions / Epilepsy		
Heart Trouble / Murmur			Bowel Trouble		
Diabetes			Glaucoma		
High Blood Pressure			Fracture		
Stroke			Hepatitis / Yellow Jaundice		
Rheumatic Fever			Thyroid Disease		
Any other Illnesses not listed above?					

FAMILY HISTORY					
Illness	**Yes**	**Relative**	**Illness**	**Yes**	**Relative**
Diabetes			Drinking Problem		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		

SOCIAL HISTORY						
Marital Status:	Married ☐		Single ☐		Widowed ☐	Divorced ☐
Alcohol	Yes	☐	No	☐	Drinks per day_____	Drinks per week_____
Drug Use	Yes	☐	No	☐		
Seat Belt Use	Yes	☐	No	☐		
Regular Exercise	Yes	☐	No	☐		
Smoking	Yes	☐	No	☐	Packs per day_____	Years_____

Patient Signature:_____ **Date:**_____/_____/_____

Provider Signature:_____ **Date:**_____/_____/_____