Confidential Health Questionnaire

NAME: _____ DATE OF BIRTH: ___/____/____ TODAY'S DATE: ____/____/____

REASON FOR VISIT: ANNUAL EXAM ☐ PREGNANCY CARE ☐

PROBLEM EXAM (Please Specify) _____

CURRENT MEDICATIONS:			
Drug Name	**Dosage**	**Drug Name**	**Dosage**
Drug Allergies:			

GYN HISTORY	**OBSTETRICAL HISTORY**
Last menstrual period (date) _____ Periods: Regular ☐ Irregular ☐ How far apart are your periods _____ How many days are your periods _____ Painful periods? Yes☐ No ☐ Are periods Light ☐ Moderate ☐ Heavy ☐ Date of last pap smear _____ History of Abnormal pap smears? Yes ☐ No ☐ Do you use any kind of birth control? Type: _____How Long ____ Are you satisfied with this method? Yes ☐ No ☐	Number of Pregnancies _____ Number of Deliveries _____ Number of Miscarriages _____ Number of Abortions _____ Number of Living Children _____ PREVIOUS SURGERY AND HOSPITALIZATIONS DATE: REASON: DATE: REASON: DATE: REASON: **Date of last Mammogram:** _____

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		

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

Confidential Health Questionnaire (Continued)

NAME: _____ DATE OF BIRTH: ____/____/_____ TODAY'S DATE: ____/____/_____

SOCIAL HISTORY				
Smoking	Yes ☐	No ☐	Packs per day _____	Years _____
Alcohol	Yes ☐	No ☐	Drinks per day _____	Drinks per week _____
Drug Use	Yes ☐	No ☐		
Seat Belt Use	Yes ☐	No ☐		
Regular Exercise	Yes ☐	No ☐		
Marital Status:	Married ☐	Single ☐	Widowed ☐	Divorced ☐

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/SKIN		
Pain in Breast	☐	☐
Discharge	☐	☐
Masses	☐	☐
Ulcers	☐	☐

	Current	Past
GENITOURINARY		
Blood in Urine	☐	☐
Pain with Urination	☐	☐
Urgency	☐	☐
Frequency of Urination	☐	☐
Incomplete Emptying	☐	☐
Stress incontinence	☐	☐
Abnormal Periods	☐	☐
Painful Intercourse	☐	☐
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: _____ Date: _____/_____/_____

Provider Signature: _____ Date: _____/_____/_____

Review of History (Update)

Provider Signature: _____ Date Reviewed: _____/_____/_____

Provider Signature: _____ Date Reviewed: _____/_____/_____

Provider Signature: _____ Date Reviewed: _____/_____/_____

Provider Signature: _____ Date Reviewed: _____/_____/_____

1791 Mulkey Road, Suite 200
Austell, GA 30106
Phone (770) 732-5400
Fax (770) 944-0327

51 Hiram Drive
Hiram, GA 30141
Phone (678) 945-8345
Fax (770) 445-2060

WELLSTAR®
Medical Group
Cobb Gynecologists

Human Papillomavirus Testing

Human Papillomavirus, or HPV, is a sexually transmissible virus. There are over 100 different types of HPV – some types are known to cause common warts and other types are known to cause cervical cancer. The types of HPV that cause warts don't generally develop into anything severe; whereas, the HPV's that cause cervical cancer can develop into potentially serious health issues. The Pap Smear screens for the thirteen (13) types of high-risk HPV that are known to cause cervical problems. This screen is done at the laboratory once they have received the pap specimen, it is not performed here.

Unfortunately, not all insurance companies cover the HPV screening test.

I understand I will be completely responsible for the amount of this test if my insurance plan should not cover it.

Date: _____

Patient Signature: _____

Witness Signature: _____
Doctor's assistant

I decline testing _____

Revised 7-1-2011

1791 Mulkey Road, Suite 200
Austell, GA 30106
Phone (770) 732-5400
Fax (770) 944-0327

51 Hiram Drive
Hiram, GA 30141
Phone (678) 945-8345
Fax (770) 445-2060

WELLSTAR®
Medical Group
Cobb Gynecologists

Date: _____

Thank you for choosing WellStar Cobb Gynecologists for your medical care. We do offer sexually transmitted disease testing at our offices. However, please be aware that some insurances may not cover all tests performed. You will be responsible for any portions your insurance did not pay. If you have questions whether a particular test is covered by your insurance, please contact your insurance company for verification. Thank you in advance for your cooperation in this matter.

Sincerely,

WellStar Cobb Gynecologists

I understand the previous statement and would like for a full sexually transmitted disease panel performed.

I do not wish for any sexually transmitted disease testing done today.

The following testing is available:

Gonorrhea/Chlamydia
H.I.V.
Syphilis
Hepatitis Panel
Herpes Culture
Herpes Types

1791 Mulkey Road, Suite 200
Austell, GA 30106
Phone (770) 732-5400
Fax (770) 944-0327

51 Hiram Drive
Hiram, GA 30141
Phone (678) 945-8345
Fax (770) 445-2060

WELLSTAR®
Medical Group
Cobb Gynecologists

To All WellStar Cobb Gyn Patients

This letter is to inform you that there may be lab services or ultrasounds ordered by your physician that may not be covered by your insurance. Any service fees not covered will be your responsibility.

If you have any questions, please discuss them with your physician and your insurance company.

Thank you,

WellStar Cobb Gyn Physician

_____ _____

Patient's signature Date