Elizabeth Street, M.D., Mary Pitcher, M.D., Laurie Leigh Robbins, M.D., Laura Cauthen, M.D., Angel S. Paas M.D.
574 Church Street, Marietta, GA 30060, 770-427-0285

PATIENT HISTORY **DATE** _____

NAME _____ **AGE** _____

ALLERGIES: List those medicines to which you are allergic.
☐ None _____

CURRENT MEDICATIONS:
☐ None _____ _____
_____ _____

MEDICAL PROBLEMS / INJURIES / ILLNESSES:

Date	Type	Date	Type

SURGERIES/HOSPITALIZATIONS:

Date	Surgery	Reason	Date	Surgery	Reason

PREGNANCY HISTORY:
Times pregnant _____
Full term births _____
Premature births _____
Miscarriages _____
Abortions _____
Living children _____
Delivery: Vaginal / Cesarean section
Complications? YES / NO

GYNECOLOGY HISTORY:
Date when your last menstrual period started: _____
Difficulty with periods? YES / NO Specify: _____
Date of last pap smear? _____ Last mammogram? _____
Have you had any abnormal pap smea YES/NO
Do you practice self-breast exams YES/NO
Are you sexually active? YES/NO
Have you had any sexually transmitted infections YES / NO
What method of birth control do you use? _____
If menopausal, date of onset: _____
Are you on hormone replacement therapy? YES/NO

SOCIAL HISTORY/PERSONAL HISTORY:
Do you smoke? YES/NO
Packs per day: _____ Years: _____
Do you drink alcohol? YES/NO
Drinks per day: _____ Drinks per week: _____
Do you use recreational drugs? YES/NO
Do you exercise regularly? YES/NO
Do you use seat belts? YES/NO
Do you have a living will? YES/NO
Do you experience domestic/sexual abuse? YES/NO
Any learning needs or disabilities? _____

FAMILY HISTORY: Any medical problems in your family?
Father _____
Mother _____
Sisters _____
Brothers _____
Others _____
Any family history of breast, ovarian, or colon cancer? YES / NO

Any religious, ethnic, or sexual practices which may affect your health care? _____

NOTES:

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Marital Status: married single divorced widowed

Number of people in household _____

School completed: high school college graduate degree other

Current or most recent job _____

DATE OF LAST IMMUNIZATION OR TEST:

Tetanus _____
Flu Shot _____
Pneumonia _____
TB skin test _____
HPV _____
Colonoscopy _____

REVIEW OF SYSTEMS

Please circle if you have any of the following illnesses or symptoms CURRENTLY or OFTEN:

Constitutional
Weight loss / Weight gain / Fever / Fatigue

Eyes/ENT/Mouth
Vision changes / Ringing in ears /Sore throat/Sinus Problems/Dental problems/Ear aches/Mouth sores/Glaucoma

Cardiovascular
Chest pain / Painful breathing / Leg swelling/Difficulty breathing on exertion/Heart palpitations/Rheumatic fever
High blood pressure/Heart disease/Heart murmer

Respiratory
Wheezing / Spitting up blood / Chronic cough/Shortness of breath/Tuberculosis/Chronic lung disease/Pneumonia/Asthma

Gastrointestinal
Frequent diarrhea / Constipation/Bloody stool/Nausea/Vomiting/Hepatitis/Jaundice/Ulcers

Genitourinary
Blood in urine / Pain with urination /Urgency/Frequency of urination/Stress incontinence/Incomplete emptying
Kidney infections/Kidney stones
Abnormal periods / Painful intercourse

Skin/Breast
Rash / Breast pain / Discharge / Masses/Ulcers

Neurological / Musculoskeletal
Dizziness/Seizures/Numbness/Muscle weakness/Trouble Walking/Arthritis/Fractures/Stroke

Psychiatric
Depression/Anxiety / Frequent crying

Endocrine
Dry skin / Abnormal thirst / Hot flashes/Diabetes/Thyroid disease

Hematologic/Lymphatic
Frequent bruises / Cuts do not stop bleeding/Enlarged lymph nodes/Anemia/Blood transfusions/Cancer

Date initially reviewed by physician with patient:

Physician signature:

Subsequent review of history:

Date reviewed: Physician Signature:

Date reviewed: Physician Signature:

Date reviewed: Physician Signature:

Date reviewed: Physician Signature: