Northeast Georgia
PHYSICIANS GROUP

OB/GYN QUESTIONNAIRE

TODAY'S DATE: ____________________ SIGN IN TIME: ____________________

NAME: ____________________ DATE OF BIRTH/AGE: ____________________

ADDRESS CHANGE: ❑ YES ❑ NO INSURANCE CHANGE: ❑ YES ❑ NO

PHARMACY NAME/LOCATION/PHONE #: ____________________

REASON FOR VISIT: ____________________

LAST MENSTRUAL CYCLE: ____________________ METHOD OF BIRTH CONTROL: ____________________

TOTAL # OF PREGNANCIES: __________ FULL TERM BIRTHS: __________ PRE-TERM BIRTHS: __________

MISCARRIAGE/ABORTIONS: __________ LIVING CHILDREN: __________ ECTOPIC PREGNANCIES: __________

LIST ANY DRUG ALLERGIES: ____________________

____

____

LIST ANY SURGERIES YOU HAVE HAD: ____________________

____

____

LIST SIGNIFICANT FAMILY MEDICAL HISTORY: ____________________

____

____

TOBACCO USE: ❑ NEVER QUIT DATE: ____________________ PRESENT/PACKS PER DAY: ____________________

SUBSTANCE ABUSE: ❑ NEVER QUIT DATE: ____________________ PRESENT: ____________________

ALCOHOL: ____________________

STAFF USE ONLY

WEIGHT: __________ B/P: __________ HGB: __________ HCG: __________

U/A: ____________________ OTHER: ____________________

DATE OF LAST PAP: ____________________ DATE OF LAST MAMOGRAM: ____________________

DATE OF LAST BONE DENSITY: ____________________ DATE OF LAST COLONOSCOPY: ____________________

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