**GWINNETT OB/GYN ASSOCIATES, P.C.**

Today's Date: _____ Chart #: _____

**PATIENT INFORMATION (please print – blue or black ink only)**

Name: _____ Age:_____ Birth Date: _____
Last First MI

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail Address: _____

Social Security Number: _____ Primary Care Physician: _____

**Employed?** (circle one) Yes No **Full-time Student?** (circle one) Yes No

Employer: _____ Work Phone: _____ Occupation: _____

Work Address: _____ City: _____ State: _____ Zip:_____

**Marital Status** (circle one) Single Married Divorced Widowed **Who referred you here?** _____

**SPOUSE INFORMATION**

Name: _____ Social Security Number: _____ Birth Date: _____

Employer: _____ Work Phone: _____ Cell Phone: _____

Work Address: _____ City: _____ State: _____ Zip: _____

**PERSON TO NOTIFY IN CASE OF EMERGENCY**

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

**INSURANCE INFORMATION**

**Primary Insurance Co. Name:** _____ Group #: _____ ID# _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ Social Security Number: _____

Date of Birth: _____ Relation to Patient (circle one) Self Spouse Mother Father Other

**Secondary Insurance Co. Name:** _____ Group #: _____ ID#: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ Social Security Number: _____

Date of Birth: _____ Relation to Patient (circle one) Self Spouse Mother Father Other

**I authorize the release of any medical information necessary to process insurance claims. My signature also authorizes payment of medical benefits to the named provider for professional services rendered. I understand that I am financially responsible for all services rendered, that there is a $30 returned check fee and that 30% will be added to my balance if my account must be referred to an agency for collection. Additionally, I understand that if I am covered by an insurance that requires a referral number, <u>it is my responsibility to obtain that referral number prior to my visit.</u>**

_____ _____
(Patient's Signature) (Date)

# GWINNETT OB/GYN ASSOCIATES, P.C.

**1700 Tree Lane Road ♦ Suite 290 ♦ Snellville, GA 30078 ♦ (770) 972-0330**

## Prenatal Record

Date: _____

Name: _____
Last First Middle Maiden Date of Birth

_____
Age Religion Race Country of Birth Marital Status (Please circle one) S M W D SEP Occupation

_____
Address Phone Number Education

_____
Name of Father of Child His Age Ht. Wt. Father of Child's Occupation

( ) _____ ( ) _____ ( ) _____
Your Business Phone Father of Child's Business Phone Your Cell Phone

**FAMILY HISTORY**: List relationship of family member with any of the following

| | | |
|---|---|---|
| **Tuberculosis** | **Psychological** | **Cancer: Colon** |
| **Hypertension** | **Epilepsy** | **Breast** |
| **Heart Disease** | **Allergies** | **Vagina/Vulva** |
| **Diabetes** | **Multiple Births** | **Cervix** |
| **Neurological** | **Birth Defects** | **Uterus** |
| | | **Ovaries** |
| **Significant Diseases:** | | **Other:** |

**MENSTRUAL HISTORY:** **Amount (circle one)**

Onset at Years | Interval Days | Duration Days | Lt. ☐ Mod. ☐ Hvy. ☐

First day of last menstrual period? Was it normal? ☐ Yes No ☐ Type of last of birth control When last used?

| YOUR PERSONAL PRIOR MEDICAL HISTORY | 0 NEG. √ POS. | REMARKS | HISTORY SINCE YOUR LAST MENSTRUAL PERIOD | 0 NEG. √ POS | REMARKS |
|---|---|---|---|---|---|
| **Heart Disease/Murmurs** | | | **Douche** | | |
| **High Blood Pressure** | | | **Nausea/Vomiting** | | |
| **Asthma, TB** | | | **Indigestion/Constipation** | | |
| **Stomach or Bowel Disease/ Hepatitis** | | | **Headache** | | |
| **Bladder or Kidney Disease/Infections, Stones** | | | **Bleeding (Specify)** | | |
| **Gonorrhea/Chlamydia/Syphilis** | | | **Vaginal Discharge** | | |
| **Genital Warts or Herpes** | | | **Swelling** | | |
| **Gyn. Disorder/Gyn. Surgery** | | | **Abdominal Pain** | | |
| **DES Exposure/Abnormal Paps** | | | **Urinary Problems** | | |
| **Nervous and Mental Problems** | | | **Viral Infection** | | |
| **Diabetes/Thyroid Problems** | | | **Other Illness/Fever** | | |
| **Phlebitis, Varicosities** | | | **X-rays** | | |
| **Epilepsy, Neurological Disorder** | | | **Accidents** | | |
| **Drug Allergies** | | | **Medications/including OTC** | | |
| **Drug Abuse/History of Use** | | | **Tobacco Use** | | **☐ Pt. Coun** |
| **Blood Disease/Transfusions** | | | **Drug Use** | | **☐ Pt. Coun** |
| **Cancer** | | | **Alcohol Use** | | **☐ Pt. Coun** |
| **Rh, ABO Sensitivity** | | | **HIV Exposure** | | **☐ Pt. Coun** |
| **Operations, Accidents, Hospitalization** | | | **Cats/Raw Meats (Toxo Risks)** | | **☐ Pt. Coun** |
| **Anesthetic Complications** | | | **Other** | | |
| **Have you had Chicken Pox?** | | | **Tattoos** | | |

**PREVIOUS PREGNANCIES:** **Full Term ☐** **Premature ☐** **Abortion/Miscarriage/Ectopic/Mole ☐** **Now Alive ☐** **Multiple Births ☐**

| No. | Year | Hospital | Length of Pregnancy | Length of Labor | Type of Delivery | Type of Pain Relief | Weight of Child | Complications | | Comments/ Sex of Child |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Mother | Child | |
| | | | | | | | | | | |
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# Gwinnett OB/GYN Associates, P.C.
## 1700 Tree Lane Rd., Ste 290
## Snellville, GA 30078

**Notice Of Privacy Practices**

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.**

**PLEASE REVIEW THIS NOTICE CAREFULLY.**

### A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

**The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices, Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices as a visible location at all times, and you may request a copy of our most current Notice at any time.**

### B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

The Office Manager or Practice Administrator at (770) 972.0330.

### C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. **Disclosures Required By Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

### D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
   - maintaining vital records, such as births and deaths
   - reporting child abuse or neglect
   - preventing or controlling disease, injury or disability
   - notifying a person regarding potential exposure to a communicable disease
   - notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - reporting reactions to drugs or problems with products or devices
   - notifying individuals if a product or device they maybe using has been recalled
   - notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
   - notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:

   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - Concerning a death we believe has resulted from criminal conduct
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, court order, subpoena or similar legal process
   - To identify/locate a suspect, material witness, fugitive or missing person
   - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. **Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances we will only make disclosures to a person or organization able to help prevent the threat.

6. **Military.** Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

7. **National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

8. **Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

9. **Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

**E. YOUR RIGHTS REGARDING YOUR IIHI:**

You have the following rights regarding the IIHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communications, you must make a written request to the address above, Attn: Medical Records Custodian. Specify the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request, however, if we do agree, we are bound by our agreement, except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to the address above, Attn: Medical Records Custodian. Your request must describe in a clear and concise fashion:

   (a) the information you wish restricted,
   (b) whether you are requesting to limit our practice's use, disclosure or both; and
   (c) to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the address above, Attn: Medical Records Custodian. In order to inspect and/or obtain a copy of your IIHI. Our practice will charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed healthcare professional chosen by us will conduct the review.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the address above, Attn: Medical Records Custodian. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is, in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the address above, Attn: Medical Records Custodian. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure, and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same l2-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of this Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at anytime.

7. **Right to Files Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact in writing:

   **Gwinnett OB/GYN Associates, P.C., ATTN: Privacy Officer, 1700 Tree Lane Road, Suite 290, Snellville, GA 30078**

   **All complaints must be submitted in writing. You will not be penalized for filing a complaint**

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IHII may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IHII for the reasons described in the authorization. Please note, we are required to retain records of your care. Again, if you have any questions regarding this notice or our health information privacy policies, please contact the Office Manager or Practice Administrator at (770) 972-0330.

**GWINNETT OB/GYN ASSOCIATES, P.C.**
**Gynecology Questionnaire**

**NAME**:_____ **DATE**:_____

**DATE OF BIRTH**:_____

**REASON FOR VISIT**: (If not routine, briefly describe main symptoms.) _____

_____

**PAST MEDICAL HISTORY:**

**List all operations you have had.**

| | OPERATION | DATE |
|---|---|---|
| A. | | |
| B. | | |
| C. | | |
| D. | | |
| E. | | |
| F. | | |

**List all illnesses you have had that required hospitalization.**

| | ILLNESS | DATE |
|---|---|---|
| A. | | |
| B. | | |
| C. | | |
| D. | | |
| E. | | |
| F. | | |

Have you ever had? (Check yes or no and give dates.)

| YES | NO | ILLNESS | DATE |
|---|---|---|---|
| ( ) | ( ) | Migraine Headaches | |
| ( ) | ( ) | Thyroid Disorder | |
| ( ) | ( ) | Pneumonia | |
| ( ) | ( ) | Tuberculosis | |
| ( ) | ( ) | Heart Murmur | |
| ( ) | ( ) | High Blood Pressure | |
| ( ) | ( ) | Rheumatic Fever | |
| ( ) | ( ) | Diabetes | |
| ( ) | ( ) | German Measles or Vaccine | |
| ( ) | ( ) | Anemia | |
| ( ) | ( ) | Convulsions or Seizures | |
| ( ) | ( ) | Ulcers | |
| ( ) | ( ) | I will accept blood products if necessary | |

| YES | NO | ILLNESS | DATE |
|---|---|---|---|
| ( ) | ( ) | Jaundice of Hepatitis | |
| ( ) | ( ) | Kidney Stones | |
| ( ) | ( ) | Kidney Infection | |
| ( ) | ( ) | Bladder Infection | |
| ( ) | ( ) | Genital Herpes | |
| ( ) | ( ) | Gonorrhea | |
| ( ) | ( ) | Syphilis | |
| ( ) | ( ) | Broken Bones | |
| ( ) | ( ) | Arthritis | |
| ( ) | ( ) | Mental Illness | |
| ( ) | ( ) | Serious Injury | |
| ( ) | ( ) | Blood Transfusion | |

Please list any additional medical conditions or illnesses:

| ILLNESS | DATE |
|---|---|
| | |
| | |
| | |
| | |
| | |
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| | |
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| | |
| | |
| | |

**REVIEW OF SYSTEMS:**
Are you currently having or have you recently had any of these symptoms? (Check "**YES**" or "**NO**")

**A. GENERAL**

| YES | NO | |
|---|---|---|
| ( ) | ( ) | Recent weight gain |
| ( ) | ( ) | Recent weight loss |
| ( ) | ( ) | Depression |
| ( ) | ( ) | Headaches |
| ( ) | ( ) | Eye pain |
| ( ) | ( ) | Spots in front of eyes |
| ( ) | ( ) | Double vision |
| ( ) | ( ) | Glasses |
| ( ) | ( ) | Deafness |
| ( ) | ( ) | Nose bleeds |

**B. CHEST AND HEART**

| YES | NO | |
|---|---|---|
| ( ) | ( ) | Palpitation |
| ( ) | ( ) | Skipped or irregular heart beats |
| ( ) | ( ) | Chest discomfort on exertion |
| ( ) | ( ) | Chest pain with breathing |
| ( ) | ( ) | Shortness of breath with exertion |
| ( ) | ( ) | Awakening at night short of breath |
| ( ) | ( ) | Shortness of breath lying down |
| ( ) | ( ) | Coughing up blood |

**C. BREASTS**

| YES | NO | |
|---|---|---|
| ( ) | ( ) | Breast lump |
| ( ) | ( ) | Breast tenderness |
| ( ) | ( ) | Nipple discharge |
| ( ) | ( ) | Family history of breast cancer |
| ( ) | ( ) | Previous mammogram date _____ |

**D. GASTROINTESTINAL**

| YES | NO | |
|---|---|---|
| ( ) | ( ) | Change in bowel habits |
| ( ) | ( ) | Constipation |
| ( ) | ( ) | Diarrhea |
| ( ) | ( ) | Bright blood in stools |
| ( ) | ( ) | Clay colored stools |
| ( ) | ( ) | Black stools |
| ( ) | ( ) | Abdominal pain |
| ( ) | ( ) | Hemorrhoids |
| ( ) | ( ) | Vomiting up blood |
| ( ) | ( ) | Painful bowel movements |
| ( ) | ( ) | Nausea or vomiting |

**E. GENITO-URINARY**

| YES | NO | |
|---|---|---|
| ( ) | ( ) | Frequent or painful urination |
| ( ) | ( ) | Difficulty holding urine |
| ( ) | ( ) | Difficulty starting urine |
| ( ) | ( ) | Excessive urine |
| ( ) | ( ) | Frequent night urination |
| ( ) | ( ) | Change of color of urine |
| ( ) | ( ) | Blood or pus in urine |
| ( ) | ( ) | Wetting in bed |

**F. EXTREMITIES**

| YES | NO | |
|---|---|---|
| ( ) | ( ) | Varicose veins |
| ( ) | ( ) | Pain in legs when walking |
| ( ) | ( ) | Blood clots in legs |
| ( ) | ( ) | Skin rashes |
| ( ) | ( ) | New or growing moles |

**Gwinnett Ob/Gyn Associates, P.C.**
**1700 Tree Lane Road, Ste. 290**
**Snellville, Georgia 30078**
**(770) 972-0330**

# Receipt of Notice of Privacy Practices
# Written Acknowledgement Form

I, _____, have received and/or reviewed a copy of Gwinnett Ob/Gyn Associates, P.C.'s Notice of Privacy Practices.

Signature of Patient _____Date_____

**FILE ON TOP OF ALL CORRESPONDENCE**

**IN LAST SECTION OF PATIENT CHART**

# GWINNETT OB/GYN ASSOCIATES, P.C.

## Gynecology Questionnaire (Sheet 2)

**NAME:** _____

**MEDICATIONS:** (List **ALL** medications that you take regularly or have taken recently, include all non-prescription drugs.)

1._____ 3._____

2._____ 4._____

**ALLERGIES:** Are you allergic to any medications, drugs, chemicals or food? (If **YES**, list which ones) _____

_____

_____

**CONTRACEPTIVE HISTORY:** (List present and previous history of birth control you have used.)

| | METHOD TYPE | DURATION OF USE | COMPLICATIONS |
|---|---|---|---|
| **PRESENT** | | | |
| **PREVIOUS** | | | |
| | | | |
| | | | |

**OBSTETRIC HISTORY:** (List all pregnancies, dates, and outcomes.)

| | DATE | DURATION | SEX | WEIGHT | COMPLICATIONS |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |

**FAMILY HISTORY:** (List family members (father, mother, sister, brother) with any current health problems and their ages. Also list deceased family members, the cause of death and their ages at death.) _____

_____

_____

Have any other blood relatives had serious medical problems or inherited problems? Any children born in the family with an abnormality?

_____

_____

_____

**SOCIAL HISTORY:**

Do you smoke cigarettes? ❒ Yes No ❒ How many/day? _____ How many years? _____

Do you drink alcohol? ❒ Yes No ❒ How many drinks/day? _____ Per week? _____

Do you get any regular exercise? ❒ Yes No ❒ How often? _____

**GYNECOLOGIC HISTORY:**

**MENSTRUAL HISTORY**

First day of last period: _____ Age first started period: _____ Usual number of days from one period to the next: _____

Usual # of days of flow: _____ Are your periods: Light ❒ Moderate ❒ Heavy Any excessive bleeding or spotting between cycles? ❒ Yes No ❒

Cramps with periods? ❒ Yes No ❒ Depression, anxiety, emotional upset before periods? ❒ Yes No ❒

**PAP SMEARS:**

Last pelvic exam: _____ Last pap smear: _____ Have you ever had an abnormal pap? ❒ Yes No ❒

If yes, what treatment was done? _____ Have your paps been normal since treatment? ❒ Yes No ❒

Did your mother take hormones while pregnant with you? ❒ Yes No ❒

**VAGINITIS:**

Yeast: _____ Trichomonas: _____ Non-specific/Bacterial Vaginitis: _____

Are you having any problem with discharge now? ❒ Yes No ❒

**SEXUAL HISTORY:**

Any problems with pain? ❒ Yes No ❒ Any problem with Orgasm? ❒ Yes No ❒ Other? _____

Any history of STDs? HPV ❒ Yes No ❒ Herpes ❒ Yes No ❒ Syphilis ❒ Yes No ❒ Hepatitis ❒ Yes No HIV ❒ Yes No ❒

Gonorrhea ❒ Yes No Chlamydia ❒ Yes No ❒ Other? _____

List any Gynecologic surgeries, dates and reasons for surgery: _____

_____

_____

_____

_____

_____

Gwinnett OB/Gyn Associates, P.C.
1700 Tree Lane Road
Suite 290
Snellville, GA 30078

# PATIENT'S CONFIDENTIALITY INSTRUCTIONS

**Patient Name _____ Acct# _____**

It is important for us to honor the confidentiality between patient and physician.
PLEASE CHECK YOUR PREFERENCE BELOW.

_____ You may discuss my medical information **ONLY** with me.

_____ I give my permission to discuss my medical information with the following people:

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

**YES** or **NO** You may leave medical information ( test results) on my voice mail at:
(circle one)

Cell # _____

Home # _____

Signed _____Date _____