WOMEN'S HEALTH ASSOCIATES OF WALTON, PC
513 GREAT OAKS DRIVE, SUITE A
MONROE, GA 30655
PHONE (770)267-836 FAX (770)207-0640

PATIENT INFORMATION

Name ____
(last) (first) (middle initial)

Date of Birth ______________________ Social Security# ______________________

Street Address ______________________ City __________ State __________ Zip __________

Phone#'s Home __________ Work __________ Cell __________

Marital status: single married divorced widowed Race: __________

Primary Care Physician: ______________________ Pharmacy: ______________________

Employer: ______________________ Occupation: ______________________

Spouse's name ______________________ Phone: ______________________

Emergency contact: ______________________ phone: ______________________

Relation to patient: ______________________

BILLING & INSURANCE INFORMATION

Responsible party: ______________________ DOB __________ SSN: __________

Relation to patient: ______________________

Primary Insurance ______________________ phone: ______________________

ID#: ______________________ Group#: ______________________

Secondary Insurance ______________________ phone: ______________________

ID#: ______________________ Group#: ______________________

AUTHORIZATION FOR TREATMENT/ASSIGNMENT AND RELEASE

I heareby authorize Drs/ Gaskins, Chongulia or any medical provider under their authorization to provide medical examinations, treatment or other services for myself or my above named dependent. I hereby authorize Insurance payment directly to Drs. Gaskins/Chongulia and all insurance benefits otherwise payable to me for services rendered on my behalf or for my dependent. I authorize the release of any medical information necessary to secure the payment of such benefits and I authorize the use of my signature below for all insurance submissions. I understand that I am fully responsible for all charges, whether or not paid by insurance.

Signature of Responsible Party: ______________________ Date __________

Email address: ______________________

Please indicate if it is okay to send test results via this email address. Yes__________ No__________

Women's Health Associates of Walton, 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

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

Women's Health Associates of Walton, 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: ____________________

Effective Date of this Notice:____________

Women's Health Associates of Walton, P.C.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, ______________________________________, have received a copy of **Women's Health Associates of Walton, P.C.**'s Notice of Privacy Practices.

__________________________   __________________
Signature of Patient   Date

I am aware that I may request a permanent copy of these privacy practices by verbal or written request.

__________________________   __________________
Signature of Patient   Date

Women's Health Associates of Walton, PC
513 Great Oaks Drive, Suite A
Monroe, GA 30655

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 ______________