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

513 Great Oaks Drive, Suite A, Monroe, GA 30655 *770-267-8368

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
Hypertension
Heart Disease
Diabetes
Neurological

Psychological
Epilepsy
Allergies
Multiple Births
Birth Defects

Cancer: **Colon**, **Breast**, **Vagina/Vulva**, **Cervix**, **Uterus**, **Ovaries**, **Other:**

Significant Diseases:

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	

Email Address: _____

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: _____

_____

_____

_____

_____

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_____

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_____