Name:			Birthda	ate:D	Oate:	
PATIENT PREF						
	nacy:					
Imaging Center:			Eastside		Brea	st Care Specialists
	Northeast Georgi	a	Northside		Other	
ALLERGIES: Ple	ease list any drug al	lergies.				
o None			0		_	
°			0		۰ .	
MEDICATIONS	: Please list any me	edications f	that you take: prescrip	otion, over the counte	r, and vitamir	ns.
IF YOU HAVE	A LIST OF MEDICAT	TONS WITH	HYOU PLEASE ASK THE	FRONT DESK TO MAK	KE A COPY ANI	D SKIP THIS SECTION <u>.</u>
	Name	2		Dosage	<u> </u>	How often
						l
HEALTH MAIN	TENANCE TESTING	DATE		RESULTS		LOCATION
MAMMOGRAN		DAIL		KESULIS		LOCATION
COLONOSCOP	1					
BONE DENSITY						
PAP SMEAR						
GENETIC TESTI	ING					
	l.		'		l.	
1. Have yo	u ever had an abno	ormal pap s	mear?			
			cually active?			
b.	If yes, have you ha	ad any new	sexual partners			
		=	Heterosexual Bisexu			
		-	o prevent pregnancy)?		_	
	-	-				
MENSTRUATING						
		Lens	th of flow:	Monthly cycles:	YES or NO	
	-		ANT / LIGHT / MODER		··•	
	heavy days:	-	,, moden			
			ed your period?			
	-	=				
		jaiuasii vä(ccination?			
MENOPAUSAL W						
	oause:		ala anal Menes / ensa	DENT / DAGT 1105		
			cle one) NEVER / CURF	KENI / PASI USE		
Have you had	d anv bleeding in th	ie last vear	'.'			

OB HISTORY: Te	HISTORY: Tell us about your pregnancies.				
Never Pregnant	Number of Pregnancies	Number of Deliveries			

Date	Outcome: Please circle	Delivery type: please circle		
	Full term / Preterm /Stillbirth /Miscarriage/Termination/Ectopic	Vaginal/C-section		
	Full term / Preterm /Stillbirth /Miscarriage/Termination/Ectopic	Vaginal/C-section		
	Full term / Preterm /Stillbirth /Miscarriage/Termination/Ectopic	Vaginal/C-section		
	Full term / Preterm /Stillbirth /Miscarriage/Termination/Ectopic	Vaginal/C-section		
	Full term / Preterm /Stillbirth /Miscarriage/Termination/Ectopic	Vaginal/C-section		
	Full term / Preterm /Stillbirth /Miscarriage/Termination/Ectopic	Vaginal/C-section		

FAMILY HISTORY: Please circle any of the following that affect a family member, indicate relationship (i.e. Mother, Father, Brother, Sister, Grandparent, Aunt, Uncle) and if they are maternal or paternal.

Disease	Family Member
Breast cancer	
Uterine cancer	
Colon/Rectal cancer	
Ovarian cancer	
Prostate cancer	
Has anyone in the family had genetic testing?	
Heart disease	
High blood pressure	
Stroke	
Thyroid disease	
Diabetes	
Osteoporosis	
Bleeding/Coagulation disorder	
Other	

Smoking **Ethnic Background:** Occupation: ____ 1. Never/Current/ Past Use 1. Caucasian Religion: -> How many cigarettes daily? ____ 3. African American **Marital Status** 2. Would like to quit? Yes/No 1. Single/ Domestic Partner/ 4. Latin **Alcohol Use:** 5. Native American Married/Separated/Divorced/ Widow 1. Never/Occasional/ Moderate/Heavy **Domestic Violence:** 6. Asian 7. Pacific Islander 2. History of alcohol abuse? Yes/ No 1. Do you feel safe at home? Yes/No 3. How many days in the last year have you 8. Jewish 2. Do you have a history of had more than 4 drinks in one day? _____ emotional/physical/sexual abuse? 9. Mediterranean 10. Eastern Europe Yes/No Drug Use: 1. Never / Current Use / Past Use 11. Western Europe Hobbies/Activities: _____ 2. Rehab: Current / Past / Never 12. French Canadian **Stress Level:** Country of Birth: _____ 13. Other:_____ 1. Low/Medium/High

SOCIAL HISTORY: Please answer ALL questions. Circle the one that applies to you or fill in the blank.

SURGICAL HISTORY:	
Date	Type of Surgery

MEDICAL HISTORY: Please check any medical problems

 Have you recently traveled to or lived in a Zika affected area? Yes/No
Do you have any symptoms associated with the Zika Virus? Yes/No

CANCER	(List Type)	GI		NEURO	LOGIC	RHEUM	ATOLOGY
0		0	Colon Polyps	0	Migraine	0	Fibromyalgia
0		0	Irritable Bowel	0	Mental Retardation	0	Lupus
0			Syndrome	0	Autism	0	Gout
HEART D	DISEASE	0	Acid Reflux	0	Multiple Sclerosis	0	Raynaud's Disease
0	High Blood Pressure	GYNEC	OLOGY	0	Parkinson's	0	Sjogren Syndrome
0	High Cholesterol	0	Dysplasia	0	Neuropathy	0	Scleroderma
0	Heart Attack	0	Endometriosis	0	Seizures	0	Chronic Fatigue
0	Cardiomyopathy	0	Fibroids	ORTHO	PEDIC		Syndrome
0	Murmur	0	Infertility	0	Osteoarthritis	0	Psoriasis
0	Pacemaker/Defibrillator	0	PCOS	PSYCHI	ATRIC	0	Rheumatoid Arthritis
DERMATOLOGY		HEMAT	OLOGY	0	ADD	UROLO	GY
0	Eczema	0	Von Willebrand	0	Anxiety	0	Kidney Stones
0	Rosacea		Disease	0	Depression	0	Interstitial Cystitis
0	Vitiligo	0	Factor V Leiden	0	Insomnia	0	Over Active Bladder
ENT		0	Coagulation Disorder	0	Bipolar Disorder	OTHER	
0	Meniere's Disease	0	DVT/Pulmonary	0	OCD	0	
0	Tinnitus		Embolism	0	PMS	0	
0	Hearing Loss	0	Sickle Cell	PULMC	NARY	0	
0	Sleep Apnea		Disease/Trait	0	Asthma	0	
ENDOCR	RINE	INFECT	IOUS DISEASE	0	Seasonal Allergies	0	
0	Diabetes	0	HIV	0	Pulmonary Fibrosis		
0	Osteopenia	0	Hepatitis	0	Emphysema		
0	Osteoporosis	0	Herpes	0	COPD		
0	Thyroid Problems	0	HPV				

REVIEW OF SYSTEMS: Please circle any problems that you are currently experiencing

MRSA Infection

CONSTITUTIONAL: fatigue, weight gain, weight loss **LUNGS**: cough, wheezing, shortness of breath

CARDIOVASCULAR: chest pain, palpitations, swelling of extremities

BREAST: mass, tenderness, skin changes, nipple discharge

GASTROINTESTINAL: abdominal pain, nausea, vomiting, constipation, bloating, diarrhea, change in bowel movements, rectal bleeding **GENITOURINARY:** urinary urgency, urinary frequency (urinating more than 8 times a day), pain with urination, pelvic pain, blood in urine, getting up at night to urinate, leaking urine, vaginal discharge, vaginal odor, vaginal itching, vaginal burning, vaginal irritation, lesions, bleeding (if you are menopausal)

ENDOCRINE: change in appetite, cold intolerance, heat intolerance

MENSTRUAL: irregular periods, PMS symptoms, heavy periods, painful periods

MENOPAUSAL: hot flashes, night sweats, vaginal dryness

SEXUAL: bleeding after intercourse, decreased sex drive, painful intercourse **NEUROLOGICAL**: headache, dizziness, memory loss, problems concentrating

HEMATOLOGIC: swollen glands **SKIN**: rash. abnormal moles, hair loss

PSYCHIATRIC: depression, anxiety, sleeps disturbances