South Georgia Physicians for Women
a UOG Practice

Social History

Name: _____ Date: _____ Age: _____ Height _____
Occupation: _____ Allergies_____

Marital Status

[ ]Single [ ]Married [ ]Divorced [ ]Separated [ ]Widow

Alcohol: [ ]No [ ]Social only [ ]Daily
Smoke: [ ]No [ ]Yes, how much?_____
Illicit drugs: [ ]No [ ]Yes, which ones?_____

Past Medical History: *(Circle all that apply)*

Acute infections
Angina
Bleeding tendencies
Cancer
Cesarean Section
Depression
Diabetes
Epilepsy
HIV
Hepatitis
Hereditary Defects
High Blood Pressure
Venereal Disease
Hyperthyroidism
Hypothyroidism
Irritable Bowel Syndrome
Kidney trouble
Liver Disease
Mental Illness
Mitral Valve Prolapse
Previous Heart Attack
Stroke
Suicide
Tuberculosis
Blood Cloths

Pap Smear

Have you ever had an abnormal pap smear?
[ ]No [ ]Yes

Past Surgeries

_____
_____
_____
_____

Past Obstetrical History

How many times have you been pregnant? _____
How many living children do you have? _____

Please List Pregnancies

Date of Birth	Boy or Girl	Baby's Weight	Vaginal / C-Sect.	Complications

Medications

See separate Medication list: [ ] No [ ] Yes
Please list all medications including: birth control, vitamins, and all over-the-counter medicines.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Family History: (Parents, brother, Sister, Children, or grandparents)

Diabetes:	[ ]Yes	[ ]No	Who? _____
Blood Clots:	[ ]Yes	[ ]No	Who? _____
Mental Illness	[ ]Yes	[ ]No	Who? _____
High Blood Pressure	[ ]Yes	[ ]No	Who? _____
Heart disease	[ ]Yes	[ ]No	Who? _____
Increased Cholesterol	[ ]Yes	[ ]No	Who? _____
Stroke	[ ]Yes	[ ]No	Who? _____
Birth Defects	[ ]Yes	[ ]No	Who? _____
Ovarian Cancer	[ ]Yes	[ ]No	Who? _____
Uterine Cancer	[ ]Yes	[ ]No	Who? _____
Breast Cancer	[ ]Yes	[ ]No	Who? _____

Other Cancers: _____

Other family Medical Problems:

_____
_____

Past Gynecologic History

Are your periods regular? [ ] No [ ]Yes
If no, describe how? _____
Your periods are: [ ] Heavy [ ] Moderate [ ] Light
Age of 1st period? _____
How many days do you bleed: _____
How strong is your cramping:
[ ]Mild [ ]Moderated [ ]Severe [ ]None
Have you ever had sexually transmitted disease?
[ ] No [ ]Yes, which one?_____
Number of lifetime sexual partners?_____
Are you currently sexually active?_____

Updated												
Staff init.												
Provider init.												