

Name _____ Age: _____ Date: _____

ANNUAL

Reason for Visit: _____

Pharmacy Name and Number: _____

Past Medical History (check all that apply):

Blood Clots/DVT _____

Abnormal Pap Smear _____

Epilepsy _____

Hypertension _____

Abnormal Mammogram _____

Diabetes _____

Osteoporosis _____

Breast Cancer _____

Explain: _____

Other Medical History: _____

Any serious medical problems, surgeries, hospitalizations since your last visit here?:

Any problems at the present (if so, describe)?

Date of :

Result (if abnormal, explain):

Last Pap Smear: _____

Normal / Abnormal _____

Mammogram: _____

Normal / Abnormal _____

Bone Density: _____

Normal / Abnormal _____

Colonoscopy: _____

Normal / Abnormal _____

Medications : list ALL medications you are currently taking, including dose:

(include prescription patches, creams and over the counter medications)

Allergies:

Do you have any drug allergies? No _____ Yes, please list: _____

Other Allergies: _____

Any new family history (check all that apply and explain):

List family member and if maternal or paternal

Cancer (include type): _____
 Heart Disease: _____
 Diabetes: _____
 Other Family Medical History: _____

Social History:

Do you smoke? If yes, packs per day _____ Drink? _____ Use Drugs? ___ Marital Status: _____
 Have you experienced depression or domestic violence? Please explain (confidentiality is guaranteed) _____

Reproductive History:

Date of last menstrual period: _____ Age at first menstrual period: _____
 If period has stopped, age at last period: _____ Sexually Active? Yes / No
 Type of Contraception: _____
 Are your period regular? Yes _____ If no, please explain: _____
 Do you experience clots while menstruating? No ___ If yes, please explain: _____
 Do you have problems with break through bleeding? No ___ If yes, please explain: _____

 Are you on Hormone Replacement Therapy? Yes _____ No _____

Please circle all of the symptoms you are CURRENTLY experiencing

Constitutional	Fatigue	Weight Loss	Weight Gain
	Loss of Appetite		
HENT	Headaches	Thyroid Mass	
Breasts	Lumps	Tenderness	Swelling
	Redness	Nipple Discharge	Changes in Breast Size
Cardiovascular	Chest Pain	Irregular Heart Beat	Limb Swelling
Respiratory	Shortness of Breath	Wheezing	Cough
Gastrointestinal	Nausea	Vomiting	Diarrhea
	Constipation	Abdominal Pain	Hemorrhoids
Genitourinary	Urgency	Frequency	Decreased Libido
	Vaginal Discharge	Possible Pregnancy	Significant PMS
	Difficulty Urinating	Leaking Urine	Pain with Urination
	Menstrual Irregularities	Menstrual Cramping	
Integument/Skin	Rash	Itching	Hair Growth Change
	Changes to Existing Skin Lesions or Moles	Acne	
Musculoskeletal	Joint Pain	Back Pain	Hip Pain
Endocrine	Loss of Hair	Cold Intolerance	Night Sweats
	Hot Flashes		
Psychiatric	Anxiety	Depression	Difficulty Sleeping
Heme-Lymph	Easy Bleeding	Easy Bruising	

W^{*falany & hulse*} WOMEN'S CENTER

SCREENING QUESTIONNAIRE

Name _____ Date _____

Please circle "Yes" or "No"

1. Do you have heavy periods? Yes No
2. Do you have pain with periods? Yes No
3. Do you have pain with intercourse? Yes No
4. Are you interested in permanent contraception? Yes No
5. Do you have fibroids? Yes No
6. Do you ever leak urine? Yes No
7. Do you leak urine with a strong urge on the way to the bathroom? Y / N
8. Do you leak urine when you cough, sneeze, laugh, lift, exercise? Y / N
9. Do you wear pads to protect your clothes from urine leaking? Y / N
10. Do you urinate frequently during the day? Yes No
11. Do you wake up at night to urinate? Yes No
12. Are you interested in a Diet Program? Yes No

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____
 Date of Birth: _____ Date completed: _____

Please circle Y to those that apply to **YOU and/or YOUR FAMILY (BLOOD RELATIVES** on both your mother OR father's side.) Please list your relationship to the individual diagnosed (including: self, mother, father, brother, sister, maternal/paternal aunt, maternal/paternal uncle, children, first cousins, nieces, nephews, paternal/maternal grandfather and paternal/maternal grandmother; **NOTE: brothers and/or sisters should be listed on mother's side**) and the age at cancer diagnosis. If you circled yes to one or more statements, you may be a candidate for a blood test to help determine if you have an inherited risk of cancer

	Self	Mother's Side	Father's Side	Age
<u>BREAST AND OVARIAN CANCER</u>				
Y N - Breast cancer before age 50				
Y N - Breast cancer after age 50				
Y N - Breast cancer in both breasts or multiple primary breast cancers				
Y N - Ovarian Cancer				
Y N - BRCA Mutation carrier				
Y N - Male breast cancer				
Y N - Triple Negative Breast Cancer (Age 50-60)				
Y N - Pancreatic Cancer				
Y N - Ashkenazi Jewish ancestry				

<u>COLON AND ENDOMETRIAL CANCER</u>				
Y N - Endometrial cancer before age 50				
Y N - Endometrial cancer after age 50				
Y N - Colorectal cancer before age 50				
Y N - Colorectal cancer after age 50				
Y N - Ovarian Cancer, any age				
Y N - Brain cancer, any age				
Y N - Gastric Cancer, any age				
Y N - Small Bowel Cancer, any age				
Y N - Pancreas/Biliary Cancer, any age				
Y N - Sebaceous adenoma				
Y N - 10 or more colon polyps found in a lifetime				
Y N - Renal pelvis cancer, any age				
Y N - MSI/ IHC abnormal (colon/endometrial)				
Y N - HNPCC/Lynch Syndrome Mutation Carrier				

<input type="checkbox"/> Patient is a candidate for genetic testing <input type="checkbox"/> Patient offered genetic test <input type="checkbox"/> Information given to patient <input type="checkbox"/> Accepted <input type="checkbox"/> Declined <input type="checkbox"/> Appointment follow up date _____

Patient's Signature _____ Date _____

Healthcare Provider's Signature _____ Date _____

W *falany & hulse* WOMEN'S CENTER

Human Papillomavirus (HPV) Testing Consent

Please read the following information below very carefully before you sign at the bottom. We will be happy to answer any questions you may have.

HPV is a virus that affects both females and males. There are 30 different types that affect the genital area. Some types can cause abnormal pap tests. The virus can be contracted or transmitted from any type of intimate genital contact. Intercourse is not necessary to contract or transmit HPV.

Please be aware that ACOG recommends anyone over the age of 30 be tested for HPV. However not all insurances will cover this. Please be aware of your insurance coverage, when considering HPV testing. We will file your claim for you; however you are responsible for any service not covered by your plan, your deductible or patient liability.

Please be advised that Falany & Hulse Women's Center. P.C does the HPV testing along with the pap test if you elect to do so.

_____ With this knowledge, I hereby **accept** the HPV testing.

_____ I hereby choose to **refuse** the HPV testing at time, unless my pap is abnormal.

Patient Signature

Date

Witness Signature

Date

10515 Bells Ferry Road • Building B, Suite 200 • Canton, Georgia • 30114
2864 E. Cherokee Dr. • Suite G • Canton, Georgia 30115
60 Highland Court • Suite 201 • East Ellijay, Georgia • 30540
(770) 720-8551 (770)720-2121 (706) 698-6400