PIERREMONT OB/GYN SPECIALISTS
DR. KRISTY WALTMAN
DR. KRISTI MICHAEL
DR. JOHN HAYNES
DR. DARRELL SANDIFER
DR. BETH GENEUX
DR. STEPHANIE SOCKRIDER

GYNECOLOGY

NAME:_____ AGE:_____ DOB:_____TODAY'S DATE:_____
Major reason for this visit:(circle all that apply) Annual visit, Hormones, Pelvic Pain, Menstrual period problems, Vaginal discharge or itching, Birth control, Involuntary loss of urine, Painful or too frequent urination, Breast lump, Breast pain, Possibly pregnant, Wanting to get pregnant

ADDITIONAL CONCERNS:_____

_____

MENSTRUAL HISTORY

Age of onset of menstrual periods	_____	
Number of days menstrual periods usually last	_____	
Do you have pain with menstrual periods?	Yes	No
Do you have P.M.S. Symptoms?	Yes	No
Do you have excessive bleeding while having menstrual periods?	Yes	No
Do you bleed between menstrual cycles?	Yes	No
Date of last mammogram	_____	
Was your last mammogram	Normal	Abnormal
Last colonoscopy	_____	
Last Bone Density	_____	
Are you sexually active?	Yes	No
Do you desire STD screening?	Yes	No

PAST FAMILY HISTORY

Please circle if any of your family(relative) have had the following. Please list relation (ex mother, maternal grandmother).

Breast Cancer -
Ovarian Cancer-
Phlebitis/Stroke/Blood clots(circle one or all that applies)-
Thyroid disease -