Welcome to Fulton County OB/GYN. As a new patient, please fill out the information found below to the best of your ability. Thank You!

PATIENT NAME			BIRTHDATE		_ AGE
MARITAL STATUS	OCCUPAT:	ION/ EMPLOY	ER		
PARTNER/BABY'S FATHE	R		TEL	EPHONE	
FATHERS ADDRESS					
FATHERS OCCUPATION/					
ALLERGIES					
MEDICATIONS					
NON-SCRIPT, HERBALS PREVIOUS HOPITALIZAT					
LIFESTYLE/ OTHER ISS	UES				
USE OF ALCOHOL:	NEVER	RARELY	MODERATE	_ DAILY	
USE OF TOBACCO:	NEVER	RARELY	MODERATE	_ DAILY	
Packs per day	Have you	quit? 🗆 Yes	□ No Start		Stop
USE OF STREET DRUGS:	NEVER	RARELY	MODERATE	_ DAILY	
Have you had exposur	e to second	d hand smok	e? □ Yes □ No		
Have you ever been i	mmunized ag	gainst the	HPV virus (Ga	rdasil) -	· 🗆 Yes 🗆 No
Have you received th If so, when?	e tetanus,	diphtheria	, pertussis(T	dap) vacc	:ine? □ Yes □ No
Do you want to be te	sted for H	IV today? □	Yes □ No		
FAMILY HISTORY (plea	se indicate Yes Who	ed yes or n	o and which r	elative)	
Diabetes High Blood Pressure Stroke Heart Disease			Breast Canc Ovarian Can Uterine Can Twins	cer	
Birth Defects			Other		

		ate of last pe					
Was you last cycl	e normal?	Yes □ No	How lo	ong do	you	cycle	es last?
Type of last Birt	h Control	used?				Dat	tes
DATE/RESULT OF LA	ST PAP		Histo	ory of	Abn	ormal	Pap? □ Yes □ No
Total # of pregna							
Miscarriages	Abortions _.	Ectopic	Mult	tiples		Living	g Children
Pregnancies							
#1)Date	Weeks	Weight	Sex	Type	of d	lelive	<u>- Ty</u>
Place of Birth		Complica	ations_				
#2)Date	Weeks	Weight	Sex	Type	of d	lelive	ſУ
Place of Birth		Complica	ations_				
#31Da+e	Waaks	Weight	Sav	Туре	of d	امانتما	C77
#3)Date Place of Birth	weeks	Complica	ations	Type	OI C	iell ve	- Y
#4)Date Place of Birth	Weeks	Weight	Sex	Type	of d	lelive	<u>-</u> Y
Place of Birth		Complica	ations_				
#5)Date	Weeks	Weight	Sex	Type	of d	lelive	ſУ
#5)Date Place of Birth		Complica	ations_				
#6)Date	Weeks	Weight				lelive:	~77
			Sex ations_	Туре	of d		
#6)DatePlace of Birth Review of Systems GENERAL UMEAKNESS IMEAGIU	(DO YOU	CURRENTLY HAVE	Sex ations_ E ANY O	Type F THES	of d		
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Review of Systems GENERAL WEAKNESS FATGIU CARDIOVASCULAR CHEST PAIN	(DO YOU	CURRENTLY HAVE WEIGHT GAIN GENITOURINARY/ FREQUENT URI	Sexations_ ations_ E ANY Old WEIGHT FEMALE NATION	Type F THES LOSS	of d	MPTOMS SKIN/B	S) R EAST H OR ITCHING
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Review of Systems GENERAL WEAKNESS FATGIU CARDIOVASCULAR CHEST PAIN	(DO YOU	CURRENTLY HAVE WEIGHT GAIN GENITOURINARY/ FREQUENT URI	Sexations_ ations_ E ANY Old WEIGHT FEMALE NATION	Type F THES LOSS	of d	SKIN/Bi RAS: CHAN VAR	S) R EAST H OR ITCHING
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The questions on this form are answered correctly to the best of my knowledge. It is my responsibility to inform the office of any changes in my medical status. I also authorize the staff to perform the necessary services which I may need.