All Women's Health OB/GYN

Tania Morgan Bowen, M.D., MPH
Christine Cope, MSN, FNP-BC
Candler Professional Building
5354 Reynolds Street, Suite 303
Savannah, Georgia 31405
Phone: 912-352-7902 / Fax: 912-352-1799

NAME ______________________________ today's Date _________
Date of Birth: _________________________ Referred by: _________________________
Check One Married ☐ Single☐ Divorced☐ Widowed ☐ Alternate Lifestyle ☐
Occupation ____
Reason for visit ____

PLEASE FILL IN ONLY THE ITEMS THAT APPLIES TO YOU.

MEDICAL HISTORY

- Blood Transfusion ☐
- Heart Disease/Murmur ☐
- High Blood Pressure / Stroke ☐
- Seizures / Epilepsy ☐
- Migraines ☐
- Depression / Psychological Illness ☐
- Lung Disease /Asthma /TB ☐
- Phlebitis / Pulmonary Embolism ☐
- Kidney Disease ☐
- Thyroid Disease ☐
- Hepatitis / Liver Disease ☐
- Diabetes ☐
- Gallbladder Disease ☐
- Anorexia / Bulimia ☐
- Cancer ☐
- Lupus / Collagen Vascular Disease ☐
- Previous Bone Fracture ☐

SURGICAL HISTORY

Date _________ Surgery _________
Date _________ Surgery _________
Date _________ Surgery _________
Date _________ Surgery _________
Date _________ Surgery _________

PERSONAL HISTORY

Current number of cigarettes a day ______
Past cigarette use (Years) ______

Alcoholic intake: Current ☐ Past ☐
Amount ___________________________
Stopped Drinking: Year _________
Drug Abuse / IV Drugs Yes ☐ No ☐
If yes list type of drug(s)
____
____

Caffeine
Coffee Soda per day _____
Number of 8oz cups of Milk per day _____
Number of 8oz cups of O.J. per day ______
Number of 8oz cups Yogurt per day _____
Number of 1oz serving cheese per day ___
Last PAP Test Date ____________________
Last Mammogram Test Date ____________
Last Cholesterol Test Date ______________

PREGANCY HISTORY

Number of Miscarriages _______ Year(s) __________
Number of Abortions _______ Year(s) __________
Number of Children _______ Year(s) __________
Type of Delivery's Vaginal/Cesarean _____________
Complications ________________________________

GYNECOLOGICAL HISTORY

Age that period began _____ Ended __________
Length of Periods ____________________
Days from one period to the next ___________________
Flow Light ☐ Moderate ☐ Heavy ☐
Current method of Birth Control ____________________
Have you ever used Birth Control Pills Yes ☐ No ☐
Have you ever use an IUD Yes ☐ No ☐

DO YOU HAVE A HISTORY OF:

- Cramps with a period ☐
- PMS ☐
- Do you perform breast Self Exams? ☐
- Breast Mass ☐
- Nipple Discharge ☐
- Abnormal PAP Smear ☐
- Cryosurgery of the cervix ☐
- LEEP / Cone Biopsy of Cervix ☐
- Condyloma / Genital Warts ☐
- Herpes ☐
- Gonorrhea ☐
- Chlamydia ☐
- Pelvis Infection ☐
- Endometriosis ☐
- Fibroids ☐
- Urinary Incontinence ☐
- Sexual Problems ☐
- Painful Intercourse ☐
- Hot Flashes ☐
- Vaginal Dryness ☐
- Infertility ☐
- DES Exposure ☐
- Ovarian Cyst ☐
- Being Raped ☐
- Being Physically Abused ☐

Allergies to medications
Yes ☐ No ☐
If yes, to what ___________________________
____
Other allergies ___________________________
Have you ever taken steroids? Yes ☐ No ☐

Current Medications / Hormones / Vitamins / Herbs: ______________________________________
____