



ATLAS MD

Patient History Form	
Name:	Birth date:
Marital Status:	Occupation:

Allergies to Medications, Latex or Dyes	<input type="checkbox"/> None <input type="checkbox"/> Yes (please list)

Medications (Prescriptions, non-prescriptions, vitamins and supplements)	<input type="checkbox"/> None <input type="checkbox"/> Yes (please list)

Surgeries/Hospitalizations/Serious Injuries	Year

Immunizations	N	Y	N	Y
Hepatitis B Series			Recent Pneumonia Vaccine	
Gardasil Series			Recent Flu Vaccine	
Chicken Pox immunization or disease			Positive TB Screening	

Health Maintenance	No	Yes	(Year)	No	Yes	(Year)
Colonoscopy				Bone Density		
Mammogram				Eye Exam		
Pap Smear				Physical Exam		

Social History	No	Yes	(Year)	(Year)
Smoking			Pack(s)/day	/years <input type="checkbox"/> Quit
Alcohol			Drinks/day	drinks/week
Caffeine			Drinks/day	
Recreational Drugs				
Special Diet			If yes describe:	
Regular Exercise			If yes describe:	
Sexually Active			<input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both	

GYN History	OB History
Age of first menses: () Menopause <input type="checkbox"/> N <input type="checkbox"/> Y (if yes Age:)	Total Number of Pregnancies: ()
Regular Periods <input type="checkbox"/> N <input type="checkbox"/> Y Painful Periods <input type="checkbox"/> N <input type="checkbox"/> Y	Full Term () Pre Term ()
PMS <input type="checkbox"/> N <input type="checkbox"/> Y - if yes describe	Miscarriages () Abortions ()
Abnormal Pap: - if Yes approximate date ()	Tubal ()
Pain with intercourse: <input type="checkbox"/> N <input type="checkbox"/> Y	Content with sex life: <input type="checkbox"/> N <input type="checkbox"/> Y