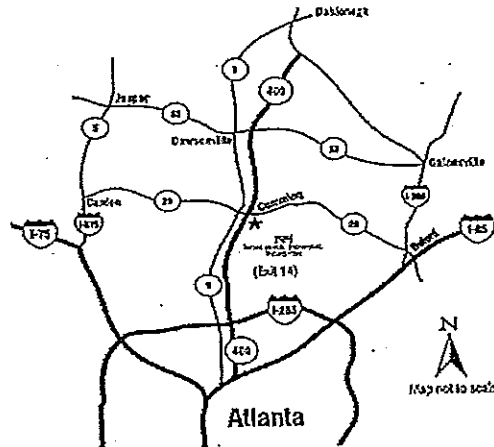


Directions to Northside Forsyth
1505 Northside Boulevard, Suite 4700
Cumming, GA 30041
(678) 442-3121



From Atlanta:

Take GA 400 North to GA 20 (Exit 14). Turn right on GA 20. At the first traffic light, make a right onto Forsyth Connector/Ronald Reagan Boulevard. At first light, make a right onto Northside Forsyth Drive. Go through first stop sign passing main entrance of Northside Forsyth Hospital. Make a left at next stop sign and another left into the parking lot of the 1505 building. There is no cost for parking. For further directions, please feel free to call Northside Forsyth Hospital at 770-844-3200.

From Lawrenceville:

Take Lawrenceville Suwanee Road for about 8 miles. It then turns into Suwanee Dam Road for about 5 miles. Turn left on Cumming Hwy for about 5.7 miles (GA-20). Make a left onto Forsyth Connector/Ronald Reagan Boulevard. At the first traffic light make a right onto Northside Forsyth Drive. Go through first stop sign passing main entrance of Northside Forsyth Hospital. Make a left at next stop sign and another left into the parking lot of the 1505 building. There is no cost for parking. For further directions, please feel free to call Northside Forsyth Hospital at 770-844-3200..

From Dahlonega/Dawsonville:

Take GA 400 South to GA 20 (Exit 14). Turn left on GA 20, then take a right on Forsyth Connector/Ronald Reagan Boulevard. At the first traffic light, make a right onto Northside Forsyth Drive. Go through first stop sign passing main entrance of Northside Forsyth Hospital. Make a left at next stop sign and another left into the parking lot of the 1505 building. There is no cost for parking. For further directions, please feel free to call Northside Forsyth Hospital at 770-844-3200.

Directions to Gwinnett Office
Medical Center Professional Park
759 Old Norcross Road
Lawrenceville, GA 30046
(678) 442-3121

Traveling North

From I-85 merge onto GA-316 via exit number 106 toward Lawrenceville/Athens. Take the Riverside Parkway exit. Turn right onto Riverside Pkwy NW. Turn left onto Old Norcross Road. Go through two traffic lights then turn left into Medical Center Professional Park. Bear left and we are first building on the left.

Traveling South

From I-85 take GA 316 east towards Lawrenceville/Athens. Exit at Riverside Parkway. Turn right onto Riverside Parkway. Turn left onto Old Norcross Road. Go through two traffic lights then turn lefts into Medical Center Professional Park. Bear left and we are first building on the left.

From Athens

Head east on 10 (78 bus route) from Athens, GA. Turn left onto 441 (129 bus route). Bear left onto US 29 west. Turn right onto US 29/78 west. Follow as road goes into US 29 west. Turn left onto US 29 west. Turn left onto US 29 west Winder Hwy SE. Bear right onto Duluth Highway (120). Go through the first light (Langley) and at the second light turn left onto Old Norcross Road. Go through two traffic lights then look for Medical Center Professional Park on right. Turn right into Medical Center Professional Park and then bear left and we are first building on the left.

Or

Routes 316 to Duluth Highway, turn left, proceed straight. Turn right on Old Norcross Road. Go through two traffic lights then look for Medical Center Professional Park on right. Turn right into Medical Center Professional Park and then bear left and we are first building on the left.

Georgia Gynecologic Oncology

980 Johnson Ferry Road • Suite 910 • Atlanta, Georgia 30342 • 404-303-3750
759 Old Norcross Road • Lawrenceville, GA 30045

THIS IS PART OF YOUR MEDICAL RECORD AND IS KEPT ABSOLUTELY CONFIDENTIAL.
COMPLETE AND ACCURATE INFORMATION ALLOWS US TO GIVE YOU THE BEST CARE POSSIBLE.

Date: _____ Referring Physician: _____

MAIN REASON FOR VISIT: Pelvic mass elevated Ca125 vaginal bleeding abnormal Pap smear fibroids
 endometrial cancer vulvar problem _____ other _____

OBSTETRICAL HISTORY: How many pregnancies have you had? _____ Vaginal deliveries _____ C-sections _____
Tubal pregnancies _____ Miscarriages _____ Abortions _____ Stillbirths _____

GYNECOLOGICAL HISTORY: Age at first period: _____ Date of last menstrual period: _____

If not menstruating, stopped at age: _____ because of menopause uterus removed for _____ (reason)

Are your periods regular somewhat irregular very irregular?

How many days between the first day of one period and the first day of your next period? _____

Menstrual flow usually lasts for _____ days total and is scant moderate heavy excessive with clots

Have you missed a period without being pregnant? Yes No

Are you currently sexually active? Yes No How do you prevent pregnancy? birth control pills condoms
 IUD tubal ligation menopause/uterus removed No method Other _____

Date of last Pap smear: _____ Have you ever had an abnormal Pap Smear? Yes No Treatment _____

MEDICAL PROBLEMS: Check any problem you have been diagnosed with or received treatment for:

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bone disease/osteoporosis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Previous cancer _____ (type) | <input type="checkbox"/> Kidney failure |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Jaundice/cirrhosis | <input type="checkbox"/> Kidney stone |
| <input type="checkbox"/> Congestive heart failure (CHF) | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Blood clot in leg or lung |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hernia | <input type="checkbox"/> Bleeding disorder (von Willebrand) |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Colitis _____ | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chronic diarrhea | <input type="checkbox"/> Skin disease _____ |
| <input type="checkbox"/> Allergies/hay fever | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Bipolar |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Sjogren's syndrome | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Back/neck/spine problems | <input type="checkbox"/> Dementia/Alzheimer's |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Migraines _____ (how often?) | <input type="checkbox"/> Other _____ |

Height: _____ Current Weight: _____ Usual Weight: _____ Age: _____

Name: _____ Date of Birth: _____

MEDICATIONS AND SUPPLEMENTS: Please list all medications, supplements and herbs.

	Name of Medication	Dosage	When do you take it?	Who prescribed it?
Diabetes	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Heart/Blood Pressure	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Anxiety/ Depression	_____	_____	_____	_____
	_____	_____	_____	_____
Other	_____	_____	_____	_____
	_____	_____	_____	_____
Over the Counter	_____	_____	_____	_____
	_____	_____	_____	_____
Herbs/Vitamins/ Supplements	_____	_____	_____	_____
	_____	_____	_____	_____

Preferred Pharmacy: CVS Rite Aid Walmart Kroger Publix Walgreens Other _____

Address: _____ Phone: _____

ALLERGIES: Please list all allergies to medications, food and materials (i.e., latex, adhesives, etc.) and the type of reaction (for example, hives, rash, swelling of throat, vomiting, etc.).

Medication and Reaction	Medication and Reaction

Name: _____ Date of Birth: _____

DOCTORS: Please list the doctors who care for you.

Specialty:	Name	Phone	Send notes?*
Gyn			<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Care			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

*Mark yes if you would like us to send information to your other doctors after each office visit.

INFECTIOUS DISEASE: Check any of the following that you have had:

Pneumonia Rheumatic Fever Tuberculosis Herpes, last outbreak _____ Syphilis Chlamydia
 Gonorrhea HIV Hepatitis type _____ Tubal Infection (PID) Frequent bladder or kidney infections or one treated in the hospital Abscess, describe: _____

SCREENING AND DIAGNOSTIC TESTS:

Date of last mammogram: _____ Date of last colonoscopy: _____

In the last year, have you had any X-Rays CT scans MRI scans Ultrasounds (sonograms)?

If yes, list body part imaged and the facility where performed: _____

SURGERY: Please list all previous surgeries.

Year	Gyn/Breast Surgery (any surgery on ovary, uterus, cervix, D&C, LEEP, C-section)	Year	Orthopedic Surgery (knee, hip replacement, back or bone surgery)
Year	Other Abdominal Surgery (colon, hernia, bowel, stomach, gallbladder)	Year	Other Abdominal Surgery (colon, hernia, bowel stomach, gallbladder)
Year	Other Surgery (eye, lung, kidney, etc.)		

Have you ever been advised to have any surgical procedure which has not been done? No Yes: _____

Have you ever been hospitalized for any illnesses? No Yes, reason/year: _____

Have you ever had a blood transfusion? No Yes, year: _____

Name: _____ Date of Birth: _____

FAMILY HISTORY: Please list any family member diagnosed with these diseases and whether they are alive (A) or deceased (D) from the disease.

	Close Family Members (child, sibling or parent)	Extended Family Members (aunts, uncles, grandparents, cousins)
Ovarian Cancer		
Breast Cancer		
Endometrial Cancer		
Cervical Cancer		
Prostate Cancer		
Colon Cancer		
Other Cancer		
Diabetes		
Tuberculosis		
Stroke		
High blood pressure		
Heart attack		

SOCIAL HISTORY:

Do you smoke? Yes No Packs per day: _____ Number of years: _____ When did you quit? _____

Do you use any other form of tobacco? Yes No If yes, type: _____

Do you use alcohol? Yes No Amount per week? _____ Type: _____

Have you ever used drugs? Yes No Past Present What type? _____

Do you exercise routinely? Yes No How often per week? _____ What type? _____

Do you have concerns about your personal safety, the personal safety of anyone in your home, or the security of your property? Yes No

Marital Status: Single Married Divorced Widowed Domestic partner

Ages of children: _____

Education: High school College Graduate school

Occupation: _____ Retired Disabled due to _____

Name: _____ Date of Birth: _____

SYSTEM REVIEW: Check any of the following symptoms that you have now or have had in the past six months.

General	<input type="checkbox"/> fevers <input type="checkbox"/> weakness/ excessive fatigue	<input type="checkbox"/> weight loss _____ lbs	<input type="checkbox"/> weight gain _____ lbs
Skin	<input type="checkbox"/> sores <input type="checkbox"/> new moles or freckles	<input type="checkbox"/> rashes <input type="checkbox"/> loss of skin pigment	<input type="checkbox"/> itching
Neurologic	<input type="checkbox"/> seizures/convulsions <input type="checkbox"/> numbness/tingling	<input type="checkbox"/> tremor <input type="checkbox"/> loss of consciousness/fainting	<input type="checkbox"/> severe headaches
Eyes, Ears, Nose, Throat	<input type="checkbox"/> ringing in the ears <input type="checkbox"/> chronic sinus infections <input type="checkbox"/> frequent throat infections	<input type="checkbox"/> any eye disease or injury _____ <input type="checkbox"/> any ear disease or injury _____	Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No dentures? <input type="checkbox"/> Yes <input type="checkbox"/> No hearing aids? <input type="checkbox"/> Yes <input type="checkbox"/> No
Breasts	<input type="checkbox"/> nipple discharge	<input type="checkbox"/> change in breast size	<input type="checkbox"/> new or changing lumps
Respiratory	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> chronic or frequent cough	<input type="checkbox"/> bloody sputum
Cardiovascular	<input type="checkbox"/> chest pain	<input type="checkbox"/> rapid/irregular heartbeat	<input type="checkbox"/> swelling of feet or ankles
Gastrointestinal	<input type="checkbox"/> diarrhea <input type="checkbox"/> vomiting <input type="checkbox"/> blood in stool <input type="checkbox"/> unable to control bowels	<input type="checkbox"/> constipation <input type="checkbox"/> heartburn or indigestion <input type="checkbox"/> black or tarry stool <input type="checkbox"/> urgency of bowel movements	<input type="checkbox"/> nausea <input type="checkbox"/> difficulty swallowing <input type="checkbox"/> abdominal cramps or pain
Gynecologic	<input type="checkbox"/> pelvic pain <input type="checkbox"/> painful sex <input type="checkbox"/> vaginal irritation/itching <input type="checkbox"/> vulvar irritation/itching <input type="checkbox"/> sores or lumps around the vulva or vagina	<input type="checkbox"/> bleeding/spotting between periods <input type="checkbox"/> bleeding/spotting after sex <input type="checkbox"/> vaginal discharge <input type="checkbox"/> bulging sensation in vagina	<input type="checkbox"/> painful periods <input type="checkbox"/> vaginal dryness <input type="checkbox"/> lumps in groin
Urinary	<input type="checkbox"/> frequent urination <input type="checkbox"/> dribbling of urine <input type="checkbox"/> bedwetting	<input type="checkbox"/> painful urination <input type="checkbox"/> sudden urgent need to urinate <input type="checkbox"/> loss of urine with sneezing or coughing	<input type="checkbox"/> night urination
Musculoskeletal	<input type="checkbox"/> back pain <input type="checkbox"/> muscle weakness	<input type="checkbox"/> joint pain/stiffness	<input type="checkbox"/> leg cramps or limp
Endocrine	<input type="checkbox"/> unusual hair growth <input type="checkbox"/> salt cravings	<input type="checkbox"/> hair loss <input type="checkbox"/> hot flashes	<input type="checkbox"/> abnormal thirst
Psychiatric	<input type="checkbox"/> nightmares <input type="checkbox"/> excessive worry/stress/tension	<input type="checkbox"/> insomnia	<input type="checkbox"/> depression

Name: _____ Date of Birth: _____