Atlanta Gynecologic Oncology

MICHELLE A. GLASGOW, MD

Welcome to Atlanta Gynecologic Oncology. It is our privilege to participate in caring for your health. We strive to provide outstanding medical expertise, state of the art therapies, and comprehensive, personalized, and compassionate care.

We believe in a team approach to health care in which the doctor and the clinical and administrative staff partner with you, the patient, to best meet your needs.

At your first visit, you'll meet Dr. Glasgow and her team. Dr. Glasgow will review your entire medical history and the details of your current condition. Dr. Glasgow will perform a complete physical exam, including pelvic exam. She'll then make recommendations for treatment and answer any questions you may have about your diagnosis. Sometimes, we'll order additional testing, like CT scans or ultrasounds, to gather more information. When surgery is the best treatment, our team will begin the scheduling process which will include a return visit for in-depth teaching with one of our nurses so you'll know what to expect.

Please review the information in this packet prior to your appointment. We have included important details about our financial and privacy policies along with a detailed history form so that we can provide the best possible care for you.

Atlanta Gynecologic Oncology employs an exceptional staff of mid-level providers (nurse practitioner and physician assistant), nurses, medical assistants and a surgical assistant with more than 45 years of combined experience in caring for gynecologic oncology patients.

We look forward to meeting you.

PHONE: 770-721-9400
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Towne Lake Office: *900 Towne Lake Parkway, Suite 302, Woodstock, GA 30189*

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ATLANTA GYNECOLOGIC ONCOLOGY

MICHELLE A. GLASGOW, MD

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 _____

GYNECOLOGIC 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: ___________________________

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: ________________________________

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

☐ Anemia	☐ Previous cancer _____________ (type)	☐ Kidney disease __________ (type)
☐ Heart blood pressure	☐ Autoimmune disease _____________ (type)	☐ Blood clot in leg or lung
☐ Heart attack	☐ Stomach ulcer	☐ Bleeding disorder__________ (type)
☐ Congestive heart failure (CHF)	☐ Gallstones	☐ Varicose veins
☐ Atrial fibrillation	☐ Jaundice/cirrhosis	☐ Seizures
☐ Mitral valve prolapse	☐ Hernia	☐ Migraines ______ (how often?)
☐ Asthma	☐ Irritable bowel syndrome	☐ Glaucoma
☐ Emphysema or COPD	☐ Colitis _____________	☐ Depression
☐ Bronchitis	☐ Hemorrhoids	☐ Anxiety
☐ Diabetes	☐ Back/neck/spine problems	☐ Schizophrenia
☐ Thyroid disease	☐ Arthritis	☐ Dementia or Alzheimer's Disease
☐ Bone disease/osteoporosis	☐ Fibromyalgia	☐ Skin disease ________________

Name:____ Date of Birth: ________________________________

NEW PATIENT HISTORY

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, qallbladder)	**Year**	**Heart Surgery** (valve or bypass surgery, stents, pacemaker/defibrillator)
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 been hospitalized for any illnesses? ☐ No ☐ Yes, reason/year: ______________________________

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

DOCTORS: Please list the doctors who care for you.

Specialty	Name	Phone
Gyn		
Primary Care		

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

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: ______________________________

____

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, foods and materials** (i.e., latex, adhesive, etc.) and the type of reaction (for example, hives, rash, swelling of throat, vomiting, etc.).

Medication & Reaction	Medication & Reaction

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 this 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		
Melanoma		
Pancreatic Cancer		
Colon Cancer		
Other Cancer		
Diabetes		
Tuberculosis		
Stroke		
High blood pressure		
Heart attack		

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic partner

Ages of children: ______________________________

Occupation: ______________________________ ☐ Retired ☐ Disabled due to ______________________________

Education: ☐ High school ☐ College ☐ Graduate School

Do you have a **Living Will** or **Advanced Directive**? ______________________________

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

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

Name:____ Date of Birth: ___________________________________