Howard Sohnen, MD
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Pinnacle Women's Health Center

308. N. Parrish Avenue
Adel, Ga 31620

Last Name: ____________________________ First Name: ________________________ Middle: _________________

Address: ____ City___________ State________ Zip___________

Home Phone______________________ Date of Birth________________ Age: __________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Number of Children: ___________ Ages____

Medications Allergies: Please list all medications to which you are allergic:

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Medications: Please list all medications that you are taking:

Drug Name____________________________ Dosage:_____________________ Frequency______________________

Drug Name____________________________ Dosage:_____________________ Frequency______________________

Drug Name____________________________ Dosage:_____________________ Frequency______________________

Drug Name____________________________ Dosage:_____________________ Frequency______________________

Drug Name____________________________ Dosage:_____________________ Frequency______________________

Past Medical History: Please check any of the following medical conditions you currently have or have had in the past:		
❑ Abnormal Heart Rhythm	❑ Emphysema	❑ Kidney Stones
❑ Alcohol Addiction	❑ Genital Warts	❑ Migraine Headaches
❑ Anemia	❑ Glaucoma	❑ Murmur
❑ Angina	❑ Gonorrhea	❑ Peptic Ulcer Disease
❑ Asthma	❑ Gout	❑ Pneumonia
❑ Cancer	❑ Heart Attack	❑ Rheumatic Fever
❑ Chlamydia	❑ Heart Failure	❑ Schizophrenia
❑ Colitis	❑ Hepatitis	❑ Seizures
❑ Depression	❑ Herpes	❑ Stroke or TIA
❑ Diabetes	❑ High Blood Pressure	❑ Thyroid Problem
❑ Elevated Cholesterol	❑ HIV or AIDS	❑ Tuberculosis

Other Medical History: Please list any other medical conditions: ____

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Surgical History: Please list any previous surgeries including dates: ____

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Social History

Have you used tobacco products: ❑ Yes ❑ No How long? _____ Quit: ❑ Yes ❑ No When?_______

Current alcohol us: ❑ Yes ❑ No Drinks per week______ Prior alcohol/drug use: ❑ Yes ❑ No

Do you have any tattoos? ❑ Yes ❑ No

OB/GYN History

Number of Pregnancies: _________________ Number of Children______________

Hysterecomy: ❑ Yes ❑ No ❑ Total ❑ Partial Reason for Hysterectomy________________________

Self Breast Exam: ❑ Yes ❑ No

Menopausal Symptoms: ❑ Yes ❑ No

PMS: ❑ Yes ❑ No

Family History

Please check the appropriate family member history:

Medical Condition:

High Blood Pressure:	❑ Father	❑ Mother	❑ Father's Parents	❑ Mother's Parents	❑ Siblings
Blood Disorder:	❑ Father	❑ Mother	❑ Father's Parents	❑ Mother's Parents	❑ Siblings
Diabetes:	❑ Father	❑ Mother	❑ Father's Parents	❑ Mother's Parents	❑ Siblings
Thyroid Disorder:	❑ Father	❑ Mother	❑ Father's Parents	❑ Mother's Parents	❑ Siblings
Depression:	❑ Father	❑ Mother	❑ Father's Parents	❑ Mother's Parents	❑ Siblings
Seizures:	❑ Father	❑ Mother	❑ Father's Parents	❑ Mother's Parents	❑ Siblings
Stroke:	❑ Father	❑ Mother	❑ Father's Parents	❑ Mother's Parents	❑ Siblings
Migraine Headaches:	❑ Father	❑ Mother	❑ Father's Parents	❑ Mother's Parents	❑ Siblings