Reproductive Surgical Specialists

1800 Northside Forsyth Drive, Suite 380, Cumming, GA 30041
p: (770) 292-2670 • f: (770) 292-2671

Carla Roberts, M.D., Ph.D.

ROOM#:_____

PLACE LABEL IN THIS SPACE

NEW PATIENT FORM

Name _____

Date of Service _____ Present Age _____

MAIN REASON FOR VISIT:

☐ Annual exam ☐ Endometriosis ☐ Pelvic pain ☐ Breast issue ☐ Vaginitis/itching ☐ Pelvic mass
☐ PCOS ☐ Vaginal bleeding ☐ Fibroids ☐ Vulvar problem
☐ Other _____

_____

DOCTORS: Please list the doctors who care for you.

Specialty:	Name	Phone	Send notes?*
Gyn			☐ Yes ☐ No
Primary Care			☐ Yes ☐ No
Pediatrician			☐ Yes ☐ No
Referred By			☐ Yes ☐ No
			☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic partner
Education: ☐ High school ☐ College ☐ Graduate school
Occupation: _____ ☐ Retired ☐ Disabled due to _____

CHIEF COMPLAINT ***(briefly tell us why you are here today?)*** _____

_____

_____

_____

_____

_____

_____

_____

_____

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MENSTRUAL, BIRTH CONTROL AND SEXUALLY TRANSMITTED INFECTIONS HISTORY

If you DO NOT menstruate, select the reason(s) why: *(Check all that apply)*

☐ Had a hysterectomy ☐ Menopause
☐ On continuous menstrual suppression using birth control (e.g. Depo-Provera, pills, Progesterone IUD)
☐ Had an endometrial ablation

When was your last menstrual period?

How old were you when your menstrual cycles started?

If you menstruate, do you CURRENTLY have any of the following symptoms DURING menstruation?
(Check all that apply)

☐ Heavy bleeding ☐ Severe pain ☐ Irregular bleeding (more than once a month) ☐ Bleeding > 7 days
☐ Mood swings ☐ Fatigue ☐ Breast tenderness ☐ Constipation ☐ Diarrhea ☐ Headaches

Do you have pain with your periods? ☐ Yes ☐ No ____ / 10 on pain scale.

Does pain start with flow? ☐ Yes ☐ No ____ / 10 on pain scale.

Do you CURRENTLY regularly (more than 3 times a month) miss school or work due to your painful period?
☐ Yes ☐ No

If you have painful periods, have you used any of the following to help with your pain during your period?
(Check all that apply)

☐ Birth control pill ☐ Vaginal ring ☐ Depo-Provera ☐ Hormonal IUD
☐ NSAIDS (e.g. Ibuprofen, Naproxen) ☐ Acetaminophen ☐ Other:

What are you using for birth control/ contraception? *(Check all that apply)*

☐ Nothing ☐ Vasectomy ☐ Condoms ☐ Birth control pills ☐ Depo-Provera injection
☐ Nexplanon implant ☐ Vaginal ring (NuvaRing) ☐ Tubal Ligation
☐ Hormonal IUD ☐ Non-Hormonal IUD Other:

Have you ever had any sexually transmitted infections (STIs)? *(Check all that apply)*

☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ HPV (Human Papilloma Virus/Warts) ☐ Syphilis
☐ PID (Pelvic Inflammatory Disease) ☐ HIV ☐ Hepatitis B ☐ Hepatitis C

GYNECOLOGIC HISTORY

Date of last exam: _____

Date and result of last Pap test: _____

Any history of abnormal Pap test? _____

Date and result of last mammogram: _____

Do you have any problems with intercourse? ____No ____Yes

Do you bleed during or after intercourse? ____No ____Yes

Do you have pain during or after intercourse? ____No ____Yes

In-utero exposure to DES (diethylstilbestrol)? ____No ____Yes

Have you used an IUD? ____No ____Yes

Have you had a tubal ligation? ____No ____Yes

Have you had surgery on or laser treatment of the cervix? ____No ____Yes

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OBSTETRICAL HISTORY

Date	Time to Conceive	Length of Pregnancy (wks)	Outcome (e.g., miscarriage, ectopic, abortion, live birth)

Were there any complications during pregnancy, labor, delivery or post partum? _____Yes _____No

If yes, please check all that apply:

☐ 4° Episiotomy ☐ C-section ☐ Vacuum ☐ Treatment for bleeding
☐ Vaginal laceration ☐ Forceps ☐ Post partum hemorrhaging ☐ Other_____

SOCIAL HISTORY

How much caffeine do you drink per day? _____ cups of coffee _____ sodas
How much alcohol do you drink per week? _____ What kind? _____
Do you use any form of tobacco? ____Yes ____No If yes, what kind? _____
How much? _____ For how long? _____
Do you vape? _____ If yes, how long? _____

EXERCISE

Do you exercise routinely? ____Yes ____No How often per week?_____ What type?_____
Have you ever received treatment for substance abuse? ____Yes ____No

What is your use of recreational drugs:

☐ Never used ☐ Used in past, but not now ☐ Presently using
☐ Marijuana ☐ Cocaine ☐ Barbiturates ☐ Amphetamine ☐ Heroin ☐ Other

SURGICAL HISTORY

Please check if you have any of the following surgeries

Procedure		Date	Surgeon	Findings
Cystoscopy (looking inside the bladder)	☐ Yes ☐ No			
Laparoscopy w/removal of Endometriosis	☐ Yes ☐ No			
Hysterectomy (removal of uterus and cervix) Were your ovaries removed? ☐ Rt ☐ Left Was the cervix retained (Supra-cervical hysterectomy)?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No			
Myomectomy ☐ Abd ☐ Laparoscopic ☐ Robotic ☐ Hysteroscopic	☐ Yes ☐ No			
Endoscopy	☐ Yes ☐ No			

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Colonoscopy	☐ Yes ☐ No			
Ovarian Cyst Removal ☐ Rt ☐ Left	☐ Yes ☐ No			
Cesarean Delivery	☐ Yes ☐ No			
Appendectomy (appendix removal)	☐ Yes ☐ No			
Cholecystectomy (gall bladder removal)	☐ Yes ☐ No			
Colectomy (removal of colon)	☐ Yes ☐ No			
Hysteroscopy	☐ Yes ☐ No			
D&C	☐ Yes ☐ No			
Ectopic: ☐ Rt ☐ Left ☐ Was tube removed	☐ Yes ☐ No			
Other:				

PAST MEDICAL HISTORY:

Please mark any of the following disorders **YOU have been diagnosed with**:

Central Nervous System:
- ☐ Seizures
- ☐ Migraine headaches
- ☐ Dementia

ENT:
- ☐ Visual disturbances
- ☐ Sinus problems

Cardiovascular:
- ☐ High blood pressure
- ☐ High blood pressure in pregnancy
- ☐ History of rheumatic fever
- ☐ Heart valve disease
- ☐ Received prophylactic antibiotics
- ☐ Mitral valve prolapse

Respiratory:
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tuberculosis

Gastrointestinal:
- ☐ IBS Irritable Bowel Syndrome
- ☐ Crohn's/ulcerative colitis
- ☐ Ulcers
- ☐ Hepatitis/liver disease
- ☐ Celiac
- ☐ Reflux

Psychiatric:
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Depression
- ☐ Eating disorders

Cancer:

Type _____

Gynecologic:
- ☐ Bladder infections (cystitis)
- ☐ Incontinence
- ☐ Kidney infections
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Herpes
- ☐ Syphilis
- ☐ Warts (HPV)
- ☐ Pelvic inflammatory disease (PID)
- ☐ Endometriosis

Musculoskeletal:
- ☐ Rheumatoid arthritis
- ☐ Lupus erythematous
- ☐ Bone fractures
- ☐ Osteoporosis

Hematological:
- ☐ Anemia
- ☐ Blood clotting disorder
- ☐ Sickle cell anemia or trait (Circle which one)

Endocrine:
- ☐ Diabetes
- ☐ Diabetes in pregnancy
- ☐ Thyroid disease
- ☐ Menopause
- ☐ Polycystic Ovary Syndrome

Other:

_____

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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)
Breast Cancer		
Cervical Cancer		
Colon Cancer		
Diabetes		
Endometrial Cancer		
Endometriosis		
Heart attack		
High blood pressure		
Other Cancer		
Ovarian Cancer		
Prostate Cancer		
Stroke		
Tuberculosis		

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

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Please list ALL medications you are presently taking. Include complementary and alternative therapies which may include over-the-counters, herbal agents, vitamins, minerals, dietary nutritional supplements, etc..

Use a separate page if necessary:

Medication	Dose	Frequency	Route of Administration	Prescribing Provider	Medical Condition

PAIN MEDICATIONS (ONLY COMPLETE THIS SECTION IF YOU ARE BEING EVALUATED FOR PELVIC PAIN)

Please list pain medication you have taken for your pain condition in the past 6 months.

Use a separate page if necessary:

Medication	Dose	Frequency	Route of Administration	Prescribing Provider	Did it help?
					☐ Yes ☐ No ☐ Still Taking
					☐ Yes ☐ No ☐ Still Taking
					☐ Yes ☐ No ☐ Still Taking
					☐ Yes ☐ No ☐ Still Taking
					☐ Yes ☐ No ☐ Still Taking
					☐ Yes ☐ No ☐ Still Taking
					☐ Yes ☐ No ☐ Still Taking
					☐ Yes ☐ No ☐ Still Taking
					☐ Yes ☐ No ☐ Still Taking
					☐ Yes ☐ No ☐ Still Taking

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

General	☐ fevers/chills	☐ flu-like	☐ dizziness	☐ weakness/excessive fatigue	
	☐ increase or decrease in appetite		☐ weight loss ____ lbs, in how much time _____		
	☐ weight gain____ lbs, in how much time _____				
Skin	☐ sores	☐ rashes	☐ itching	☐ new moles or freckles	☐ loss of skin pigment
Neurologic	☐ seizures/convulsions	☐ tremor	☐ headaches	☐ avra	☐ severe headaches
	☐ numbness/tingling	☐ loss of consciousness/fainting			☐ difficulty with memory
Eyes, Ears, Nose, Throat	☐ sinus problems		☐ any eye disease or injury		☐ vision changes
Breasts	☐ nipple discharge		☐ change in breast size		☐ new or changing lumps
Respiratory	☐ shortness of breath		☐ chronic or frequent cough		
Cardiovascular	☐ chest pain		☐ rapid/irregular heartbeat		☐ swelling of feet or ankles
Gastrointestinal	☐ diarrhea		☐ constipation		☐ nausea
	☐ vomiting		☐ urgency of bowel movements		☐ abdominal cramps or pain
	☐ blood in stool		☐ difficulty swallowing		
Gynecologic	☐ pelvic pain		☐ bleeding/spotting between periods		☐ difficulty sex drive
	☐ painful sex		☐ bleeding/spotting after sex		☐ painful periods
	☐ vaginal irritation/itching		☐ vaginal discharge		☐ vaginal dryness
	☐ vulvar irritation/itching		☐ bulging sensation in vagina		☐ hot flashes/night sweats
	☐ sores or lumps around the vulva or vagina				
Urinary	☐ frequent urination		☐ painful urination		☐ sudden urgent need to urinate
	☐ loss of urine with sneezing or coughing				
Musculoskeletal	☐ back pain		☐ joint pain/stiffness		☐ muscle weakness
Endocrine	☐ unusual hair growth		☐ hair loss	☐ abnormal thirst	☐ acne
	☐ salt cravings		☐ hot flashes	☐ heat/cold intolerance	
Psychiatric	☐ panic attacks	☐ insomnia	☐ depression	☐ excessive worry/stress/tension	

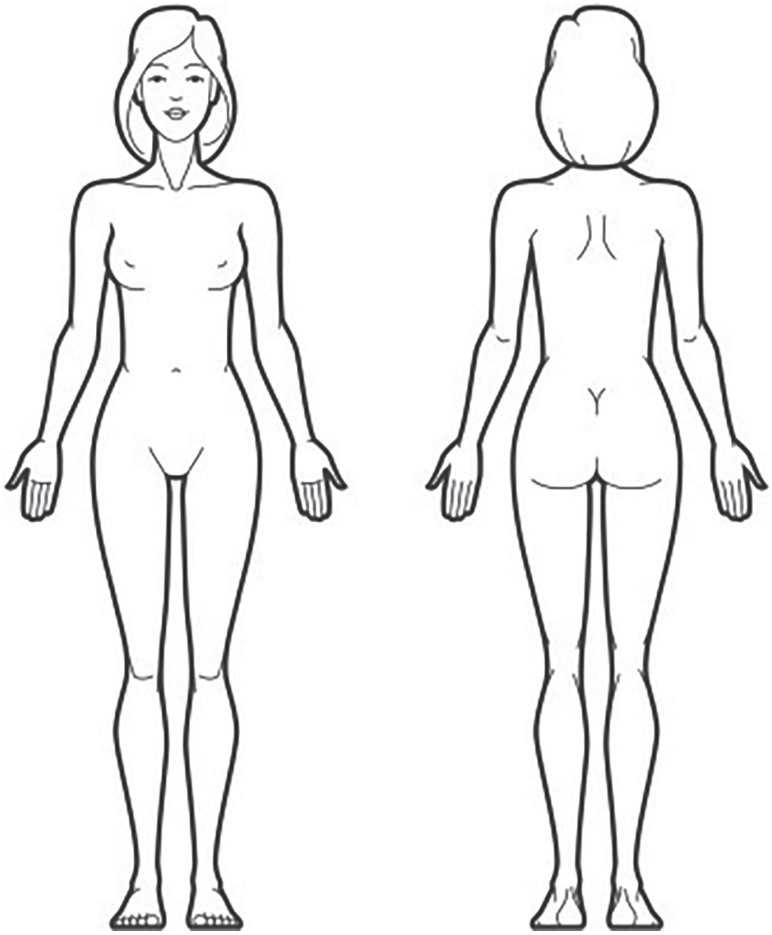
Continue and complete pages 8 and 9 if you are being evaluated for <u>Pelvic Pain</u>.

If not, STOP here.

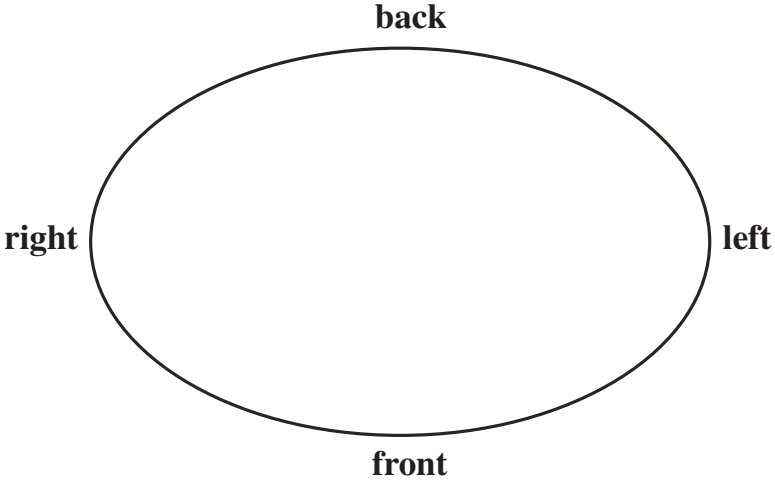
PELVIC PAIN

ANSWER ALL QUESTIONS AS IF YOU'RE HAVING YOUR MOST SEVERE DAY OF PAIN

On the diagrams below, shade in <u>all the areas of your body where you feel pain</u>.
If there is an area that hurts more than anywhere else, put an X on that area.



Then shade the inside view of the pelvis to show pain that is deep.

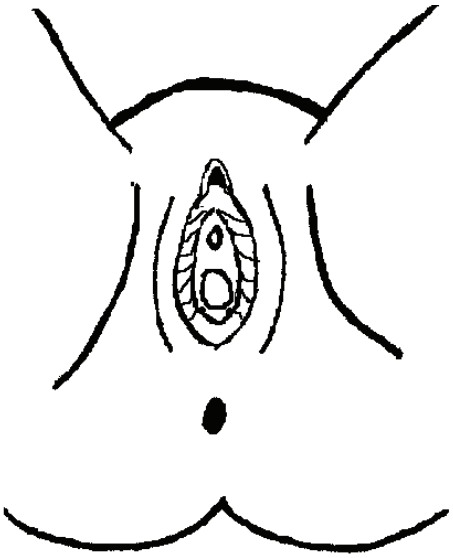


Vulvar / Perineal Pain

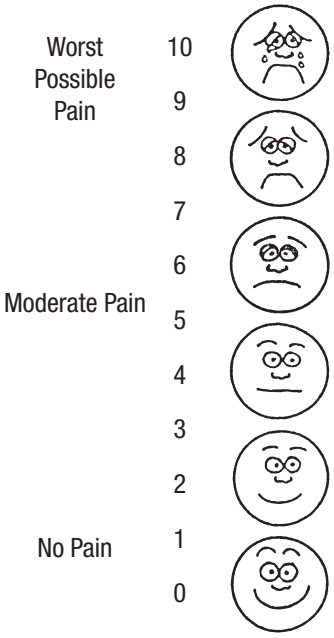
(pain outside and around the vagina and rectum)

If you have vulvar pain, shade the painful areas.

Is your pain relieved by sitting on a commode seat? ☐ Yes ☐ No



Please circle your level of pain below.



Patient initial _____

PAIN HISTORY, DESCRIPTION AND CONTRIBUTING FACTORS

When did your pain begin? Month: Year: ☐ Unsure

Please use your own words to describe your pain:

How did your main pain begin, do you recall a specific incident that occurred when your pain first began? *(Check one)*

☐ Periods/1st period ☐ Medical condition other than cancer ☐ No obvious cause/ do not know a specific incident
☐ After surgery ☐ Sexual/Abuse ☐ Other:

How did your pain begin? *(Check only one)* ☐ Suddenly ☐ Gradually

How long has your main pain been present? *(Check only one)*

☐ Less than 3 months ☐ 3-12 months ☐ 12 months - 2 years ☐ 2-5 years ☐ More than 5 years

Since your pain began, is your pain: *(Check only one)*

☐ No different ☐ Getting better ☐ Getting worse ☐ I don't know

Which statement best describes your pain? *(Check only one)*

☐ Always present (always the same intensity)
☐ Always present (level of pain varies)
☐ Often present (pain free periods less than 6 hours)
☐ Occasionally present (once to several times per day lasting up to an hour)
☐ Rarely present (pain occurs every few days or weeks)

How would you describe your pain: *(Check all that apply)*

☐ Sharp, stabbing ☐ Crampy ☐ Heavy feeling in the pelvis ☐ Dull, achy pain
☐ Pulling, tugging pain ☐ Throbbing pain ☐ Burning pain ☐ Falling out sensation
☐ Other:

Does your pain ever wake you up from your sleep? ☐ Yes ☐ No

Does your pain ever radiate or spread to other regions of your body? ☐ Yes ☐ No

What makes your pain WORSE? *(Check all that apply)*

☐ Walking ☐ Climbing stairs ☐ Urination ☐ Heavy lifting ☐ Nothing makes is worse
☐ Full bladder ☐ Stress ☐ Housework ☐ The weather ☐ Getting in/out of the car
☐ Exercise ☐ Menstrual period ☐ Contact with clothing ☐ Intercourse/Sexual contact
☐ Bowel movements ☐ Other:

What makes your pain BETTER? *(Check all that apply)*

☐ Lying down/rest ☐ Emptying bladder ☐ Ice or Heating pad ☐ Nothing makes it better
☐ Meditation ☐ Laxatives/enema ☐ It goes away by itself ☐ When I feel supported
☐ Hot bath ☐ Massage ☐ Bowel movements ☐ When my stress is low
☐ Exercise ☐ Ibuprofen or Tylenol ☐ Prescription pain medications
☐ Being distracted, when I am busy doing other things ☐ Other:

Has pain forced you to give up or change your type of work? ☐ Yes ☐ No

If yes, how has pain changed your work?

a. Changed to a less strenuous, but full-time job? ☐ Yes ☐ No
b. Changed to part-time work? ☐ Yes ☐ No
c. If disabled, how long have you been unable to work? _____

PATIENT STOPS HERE

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Declined Done _____ by primary physician

☐ No physical exam performed. Talk only.

ASSESSMENT/PLAN

CONSTITUTIONAL (Comprehensive exam requires at least 3 vital signs plus general appearance)
• Any 3 VITAL SIGNS Ht_____ Wt_____ BP_____ P_____ R_____ T_____ BMI_____
• General appearance (Note all that apply)

☐ Well		☐ Other
☐ Well-nourished		☐ Other
☐ Normal habitus	☐ Obese, overweight	☐ Other
☐ No deformities		☐ Other
☐ Well groomed		☐ Other

NECK

• Palpation	☐ Supple, no masses	☐ Abnormal
• Thyroid	☐ No thyromegaly, nodules, goiter	☐ Abnormal

RESPIRATORY

• Respiratory effort	☐ Normal	☐ Abnormal
• Auscultation of lungs	☐ Clear bilaterally	☐ Abnormal

CARDIOVASCULAR

• Auscultation of heart	☐ RRR, no murmurs, rubs or gallop	☐ Abnormal
• Peripheral vascular	☐ + dorsalis pedis bilaterally, no varicosities	☐ Abnormal

GASTROINTESTINAL (Comprehensive exam requires all bulleted items)

• Abdominal	☐ Soft, non-tender	☐ Abnormal
• Hernia	☐ None	☐ Abnormal
• Liver/Spleen		
Liver	☐ Normal	☐ Abnormal
Spleen	☐ Normal	☐ Abnormal
• Stool guaiac indicated	☐ No	☐ Yes/Result _____

LYMPHATIC
• Palpation of nodes (Note all that apply)

Neck	☐ Normal	☐ Abnormal	Axilla	☐ Normal	☐ Abnormal
Groin	☐ Normal	☐ Abnormal	Other site	☐ Normal	☐ Abnormal

SKIN

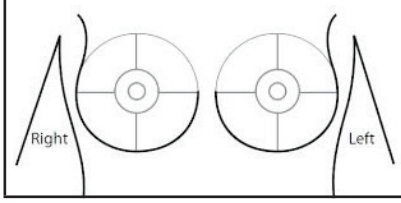
Inspect/palpate	☐ No rashes, lesions, induration, ulcers	☐ Abnormal

NEUROLOGIC/PSYCHIATRIC
• Orientation
☐ Time ☐ Place ☐ Person ☐ Comments
• Mood and Affect
☐ Normal ☐ Depressed ☐ Anxious ☐ Agitated ☐ Other

GYNECOLOGICAL (Comprehensive exam requires at least 7 bulleted elements)

• Vaginal/pelvic support	☐ Pink, moist, non-tender	☐ Abnormal
• Rectal	☐ No mass or fissure	☐ Abnormal
• Cervix	☐ Pink, no lesions	☐ Abnormal
• Uterus	☐ Mobile, non-tender	☐ Abnormal
• Adnex/parametria	☐ No mass, non-tender	☐ Abnormal
• Bladder	☐ No mass, non-tender	☐ Abnormal

• Breast ☐ Normal ☐ Abnormal:



• External genitalia ☐ Normal ☐ Abnormal:
• Urethral meatus ☐ Normal ☐ Abnormal:
• Anus/perineum ☐ Normal ☐ Abnormal:

Assessment
Rubella status: Immune Non-immune Unsure Desires testing _____ Declines testing _____
Cystic fibrosis testing offered Desires testing _____ Declines testing _____ Desires genetic counseling _____
Varicella status: Had chicken pox Unsure Desires testing _____ Declines testing _____
Folate supplementation: _____
Genetic consultation: _____

LEVEL OF HISTORY		REQUIREMENTS FOR LEVELS OF HISTORY		
	1. CC	2. HPI	3. PFSH	4.ROS
Problem Focused 01	Required	Brief(l-3)	N/A	N/A
Expanded Problem Focused 01	Required	Brief(l-3)	N/A	Problem Pertinent (1)
Detailed 01	Required	Extended (4+)	Complete (3)	Complete (3)
Comprehensive 04	Required	Extended (4+)	Complete (3)	Complete (10)