1800 Northside Forsyth Drive, Suite 380, Cumming, GA 30041
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PLACE LABEL IN THIS SPACE

☐ CARLA ROBERTS, MD, PHD
☐ CYNTHIA WITT, FNP-C

ROOM#:_______________

NEW PATIENT FORM

Name ______________________________

Date of Service ______________________ Present Age ______________

Physician who referred you ______________________ Fax: ______________

Physician Address ______________________________

Would you like your referring physician to receive information from your visit today?

If yes, sign here: ______________________________

PATIENT DEMOGRAPHIC INFORMATION

Address ______________________________

City ______________________ State __________ Zip ______________

Your Occupation ______________________________

Home Phone ______________ Work Phone ______________ Other Phone ______________

Education:

Less than 12 years   High School graduate   Technical School

College degree   Post-graduate degree

Who do you live with? ______________________________

What type of work are you trained for? ______________________________

What type of work are you doing? ______________________________

What type of work does your partner do? ______________________________

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

____

____

____

____

____

____

____

____

PP0289 (RSS) NEW PATIENT PACK

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MENSTRUAL HISTORY

Are you having periods? ____ YES ____ NO When was your first period? ________________________

If NO, the reason is ☐ never had period ☐ hysterectomy ☐ uterine ablation ☐ medical/hormonal

Medication to suppress period: ____

First day of your last menstrual period: ____

Bleeding is/used to be ☐ light ☐ moderate ☐ heavy ☐ bleeding through protection

How many days between the **start** of each period? ________________________________

How many days of menstrual flow? ____

Do you have pain with your periods? ☐ YES ☐ NO Pain is _______/10 on pain scale.

Does pain start the day flow starts? ☐ YES ☐ NO Pain is _______/10 on pain scale.

Are your periods regular? ☐ YES ☐ NO

Do you pass clots in your menstrual flow? ☐ YES ☐ NO

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

IMMUNIZATIONS

Have you had rubella (German measles) or a vaccine? ____No ____Yes Date of vaccine ____________________

Have you had varicella (chicken pox) or a vaccine? ____No ____Yes Date of vaccine ____________________

____ I am up to date on all of my vaccines.

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 ______________________________

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SOCIAL HISTORY

Are you (check all that apply): ___married ___widowed ___separated ___divorced
___remarried ___single ___single in a committed relationship

How much caffeine do you drink per day? __________ cups of coffee _________sodas

How many cigarettes do you smoke per day? __________ cigarettes/packs (circle) For how long:_______years

How much alcohol do you drink per week? __________ What kind? ____

EXERCISE

Type Hours per Week Days per Week

____

____

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

SURGERY HISTORY

Procedure	Surgeon/Hospital	Year	Findings	Outcome (if for pain)

Have you ever been hospitalized for anything other than childbirth or surgeries? ____Yes ____No

If yes, please explain:

____

____

____

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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
- ☐Chron'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 factures
- ☐ Osteoporosis

Hematological:
- ☐ Anemia
- ☐ Blood clotting disorder
- ☐ Sickle cell anemia or trait

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

Other:

____

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FAMILY HISTORY

Fill in the circles to identify all illness and conditions that you know have occurred in your blood relatives.

	Partner	Father	Mother	Brothers	Sisters	Sons	Daughters	Grandparents
Uterine Cancer	○	○	○	○	○	○	○	○
Colon Cancer/Rectal Cancer	○	○	○	○	○	○	○	○
Prostate Cancer	○	○	○	○	○	○	○	○
Ovarian Cancer	○	○	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○	○	○
Other Cancer (Type:__________________)	○	○	○	○	○	○	○	○
Heart Defects	○	○	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○	○
Asthma	○	○	○	○	○	○	○	○
Dementia/Alzheimer's	○	○	○	○	○	○	○	○
Tuberculosis (TB)	○	○	○	○	○	○	○	○
Seizure Disorder	○	○	○	○	○	○	○	○
Stroke/TIA	○	○	○	○	○	○	○	○
High Cholesterol	○	○	○	○	○	○	○	○
Abnormal Bleeding (Bleeding Disorder)	○	○	○	○	○	○	○	○
Blood Clots	○	○	○	○	○	○	○	○
High Blood Pressure	○	○	○	○	○	○	○	○
Anemia	○	○	○	○	○	○	○	○
Endometriosis	○	○	○	○	○	○	○	○
Hepatitis	○	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○	○
Osteoporosis	○	○	○	○	○	○	○	○
Alcohol Abuse	○	○	○	○	○	○	○	○
Depression	○	○	○	○	○	○	○	○
Eating Disorders	○	○	○	○	○	○	○	○
Other Psychiatric/Mental Illness	○	○	○	○	○	○	○	○
Anesthesia Complications	○	○	○	○	○	○	○	○
Kidney Disease	○	○	○	○	○	○	○	○
Miscarriages	○	○	○	○	○	○	○	○
Mental Retardation	○	○	○	○	○	○	○	○
Down Syndrome	○	○	○	○	○	○	○	○
Cystic Fibrosis	○	○	○	○	○	○	○	○
Stillbirth	○	○	○	○	○	○	○	○
Spina Bifida (Spine or Brain Defects)	○	○	○	○	○	○	○	○
Cleft Lip or Palate	○	○	○	○	○	○	○	○
Tay Sachs, Gaucher's, Canavan's Disease	○	○	○	○	○	○	○	○
Neurofibromatosis	○	○	○	○	○	○	○	○
Thalassemia/Sickle Cell	○	○	○	○	○	○	○	○
Other (Discuss with Care Provider)	○	○	○	○	○	○	○	○

ALLERGIES AND MEDICATIONS

Please list any allergies or sensitivities to medications and associated reactions.

____

____

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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REVIEW OF SYSTEMS

Please mark any of the following symptoms that **you are currently experiencing**.

Central Nervous System:
- ☐ Headaches
- ☐ Difficulty with memory

ENT:
- ☐ Visual disturbances
- ☐ Sinus problems

Cardiovascular:
- ☐ Chest pain
- ☐ Palpitations
- ☐ Dizziness

Respiratory:
- ☐ Shortness of breath
- ☐ Cough

Gastrointestinal:
- ☐ Nausea/vomiting
- ☐ Blood in stool
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal Pain

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

Gynecologic:
- ☐ Incontinence
- ☐ Decreased sex drive
- ☐ Pelvic pain
- ☐ Breast discharge
- ☐ Hot flashes/night sweats
- ☐ Pain with or difficulty urinating
- ☐ Vaginal discharge
- ☐ Vaginal or vulvar itching

Musculoskeletal:
- ☐ Joint Pain

Hematological:
- ☐ Bleeding tendency/easy bruising

Endocrine:
- ☐ Heat or cold intolerance (circle)
- ☐ Excessive hair growth
- ☐ Unintended Rapid weight gain or loss (circle)
- ☐ Excessive thirst or hunger (circle)
- ☐ Acne/skin problems
- ☐ Hair loss

Constitutional:
- ☐ Flu-like symptoms
- ☐ Increase or decrease in appetite (circle)
- ☐ Wight gain or loss (circle)
- ☐ Fever or chills
- ☐ Fatigue

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IF YOU ARE NOT HERE FOR INFERTILITY EVALUATION SKIP TO **"PAIN EVALUATION, PAGE 10"**.

INFERTILITY HISTORY

How long have you been trying to get pregnant?______years_______months
If primary (no prior pregnancy), have you attempted pregnancy prior to this relationship? ____Yes ____No
If secondary (prior pregnancy), is this the same person who fathered your last child? ____Yes ____No

PAST INFERTILITY EVALUATION FOR COUPLE

Details of Previous Test: (give dates and results for all positives)
Semen Analysis ____No ____Yes Result______________________________
BBT Charts ____No ____Yes Result______________________________
Endometrial Biopsy ____No ____Yes Result______________________________
HSG (X-ray of tubes) ____No ____Yes Result______________________________
Ovulation Predictor ____No ____Yes Result______________________________
Laparoscopy ____No ____Yes Result______________________________
Hysteroscopy ____No ____Yes Result______________________________
Hormonal Tests:
Prolactin ____No ____Yes Result______________________________
TSH ____No ____Yes Result______________________________
Day 3 FSH, Estradiol ____No ____Yes Result______________________________
Progesterone ____No ____Yes Result______________________________
Details of Previous Treatments: (include dose/number of cycles)
Clomiphene (Clomid) ______________________________
Gonadotrophins______________________________
Insemination ______________________________

ETHNICITY

☐ Northern European ☐ African-American ☐ French Canadian ☐ Jewish ☐ Mediterranean

PAST IVF CYCLES

IVF Program	Date	FSH Dose	Peak E2	# Ooctyes Retrieved	% Fertilization	Outcome

Reproductive Surgical Specialists

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PARTNER HISTORY - COMPLETE THIS PAGE ONLY IF INFERTILITY

IF INFERTILITY:

Partner's Name ____ Age________ Date of Birth__________________________
Partner's Occupation ____________________________________ Partner's Work Phone________________________________
Birth date of husband/partner_____________________Present age__________________
Duration of present relationship_______________________
Has husband/partner initiated a pregnancy in a previous relationship? ____No ____Yes
If yes, please give dates and outcome of pregnancy. ____
Any stillbirth, miscarriage or pregnancy with birth defect or genetic disorder? ____No ____Yes
Has husband/partner experienced infertility in a pervious relationship? ____No ____Yes
Any history of the following?

Prostatitis	____No ____Yes
Epididymitis	____No ____Yes
Orchitis	____No ____Yes
Previous vasectomy	____No ____Yes
Testicular tumor	____No ____Yes
Injury to testes	____No ____Yes
Undescended testicles	____No ____Yes
Gonorrhea	____No ____Yes
Chlamydia	____No ____Yes
Syphilis	____No ____Yes
Nonspecific urethritis	____No ____Yes
Difficulty with erection	____No ____Yes
Difficulty with ejaculation	____No ____Yes
Exposure to radiation	____No ____Yes
Exposure to chemical	____No ____Yes
Exposure to toxic substances	____No ____Yes
Exposure to high temperatures	____No ____Yes

PARTNER MEDICAL HISTORY

Present Weight______Height__________
List all significant medical Illnesses (Including names of physicians/facilities):
____
____

List all surgical procedures (including dates and facilities):
1. ____
2. ____
3. ____
4. ____

List current medications (name of the drug, reason you take it and how long you have taken it):

Medication Indication Dates Taken

1. ____
2. ____
3. ____
4. ____

Social history

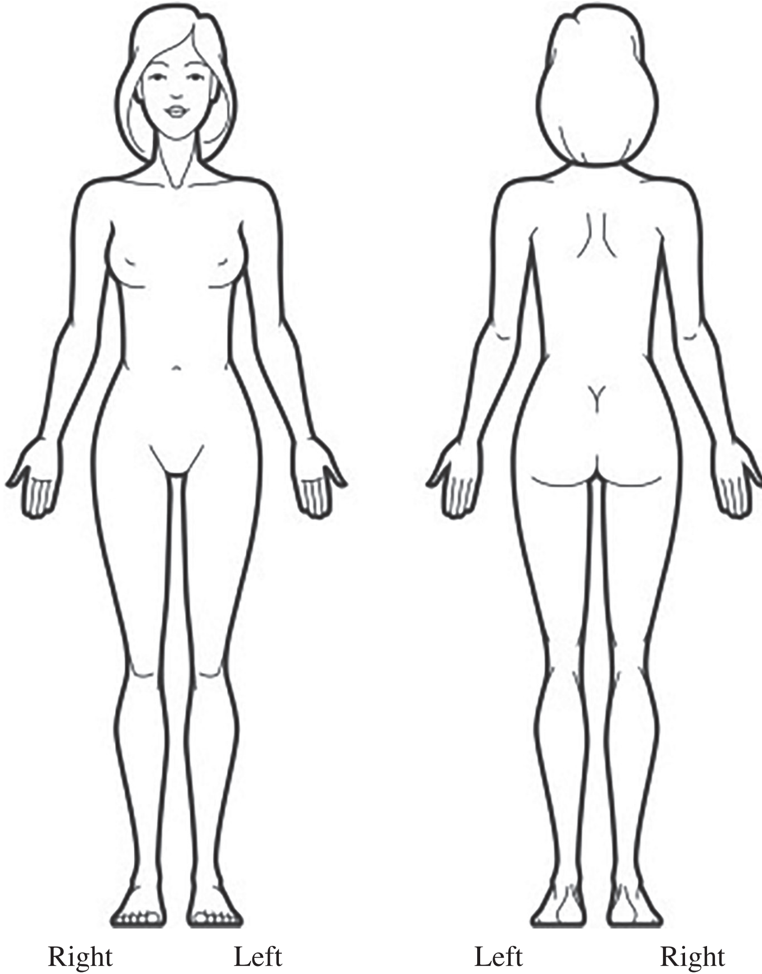
How much caffeine does your partner drink per day? __________ cups of coffee _________sodas
How many cigarettes does your partner smoke per day? __________ cigarettes/packs (circle) For how long:_______years
How much alcohol does your partner drink per week? __________ What kind?__________________________________

Complete pages 10 and 11 if you are being evaluated for <u>Pelvic Pain</u>.

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.

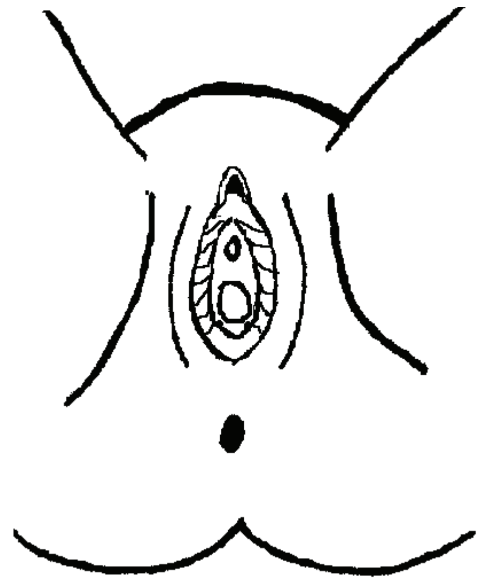


Vulvar / Perineal Pain

(pain outside and around the vagina and rectum)

If you have vulvar pain, shade the painful areas.

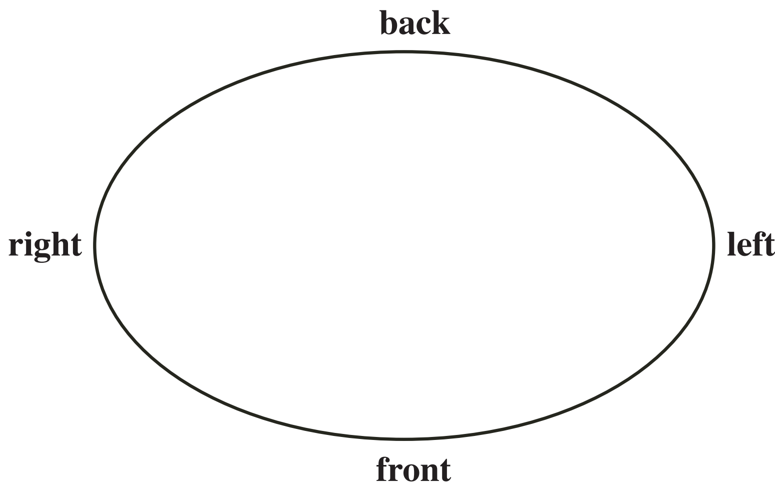
Is your pain relieved by sitting on a commode seat? ☐ Yes ☐ No



Please circle you level of pain below.

	Pain level
Worst Possible Pain	10
	9
	8
	7
	6
Moderate Pain	5
	4
	3
	2
	1
No Pain	0

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



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Your age when you first started having pain:______________________________

If your pain had gone away and now has returned, what age did it return? ______________________________

What do you think is causing your pain? ______________________________

Is there an event that you associate with the onset of your pain? ____Yes ____No

If yes, what? ______________________________

How long have you had this?_________years _________months

Please tell us how the pain started or the circumstances related to its onset:

____

____

How has the intensity of your pain changed over the past several months?

☐ Increased ☐ Decreased ☐ Stayed the same ☐ Varied

Dates (years only) of Ultrasound: ______________________________

MRI: ______________________________

CT Scan: ______________________________

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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