



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			<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Care			<input type="checkbox"/> Yes <input type="checkbox"/> No
Pediatrician			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> 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

If you have painful periods, how long have you had this type of pain? Please specify years or months.

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) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Laparoscopy w/removal of Endometriosis <input type="checkbox"/> Yes <input type="checkbox"/> No			
Hysterectomy (removal of uterus and cervix) <input type="checkbox"/> Yes <input type="checkbox"/> No Were your ovaries removed? <input type="checkbox"/> Rt <input type="checkbox"/> Left Was the cervix retained (Supra-cervical hysterectomy)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Myomectomy <input type="checkbox"/> Abd <input type="checkbox"/> Laparoscopic <input type="checkbox"/> Robotic <input type="checkbox"/> Hysteroscopic <input type="checkbox"/> Yes <input type="checkbox"/> No			
Endoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No			

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Colonoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Ovarian Cyst Removal <input type="checkbox"/> Rt <input type="checkbox"/> Left	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Cesarean Delivery	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Appendectomy (appendix removal)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Cholecystectomy (gall bladder removal)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Colectomy (removal of colon)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Hysteroscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No			
D&C	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Ectopic: <input type="checkbox"/> Rt <input type="checkbox"/> Left <input type="checkbox"/> Was tube removed	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Other:				

PAST MEDICAL HISTORY:

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

<p>Central Nervous System:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Seizures <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Dementia <p>ENT:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Visual disturbances <input type="checkbox"/> Sinus problems <p>Cardiovascular:</p> <ul style="list-style-type: none"> <input type="checkbox"/> High blood pressure <input type="checkbox"/> High blood pressure in pregnancy <input type="checkbox"/> History of rheumatic fever <input type="checkbox"/> Heart valve disease <input type="checkbox"/> Received prophylactic antibiotics <input type="checkbox"/> Mitral valve prolapse <p>Respiratory:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tuberculosis <p>Gastrointestinal:</p> <ul style="list-style-type: none"> <input type="checkbox"/> IBS Irritable Bowel Syndrome <input type="checkbox"/> Crohn's/ulcerative colitis <input type="checkbox"/> Ulcers <input type="checkbox"/> Hepatitis/liver disease <input type="checkbox"/> Celiac <input type="checkbox"/> Reflux <p>Psychiatric:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety <input type="checkbox"/> Panic attacks <input type="checkbox"/> Depression <input type="checkbox"/> Eating disorders 	<p>Cancer:</p> <p>Type _____</p> <p>Gynecologic:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bladder infections (cystitis) <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney infections <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> Herpes <input type="checkbox"/> Syphilis <input type="checkbox"/> Warts (HPV) <input type="checkbox"/> Pelvic inflammatory disease (PID) <input type="checkbox"/> Endometriosis <p>Musculoskeletal:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Lupus erythematosus <input type="checkbox"/> Bone fractures <input type="checkbox"/> Osteoporosis <p>Hematological:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia <input type="checkbox"/> Blood clotting disorder <input type="checkbox"/> Sickle cell anemia or trait (Circle which one) <p>Endocrine:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes <input type="checkbox"/> Diabetes in pregnancy <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Menopause <input type="checkbox"/> Polycystic Ovary Syndrome <p>Other:</p> <p>_____</p>
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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		
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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SYSTEM REVIEW: Check any of the following symptoms that you have now or have had in the past six months.

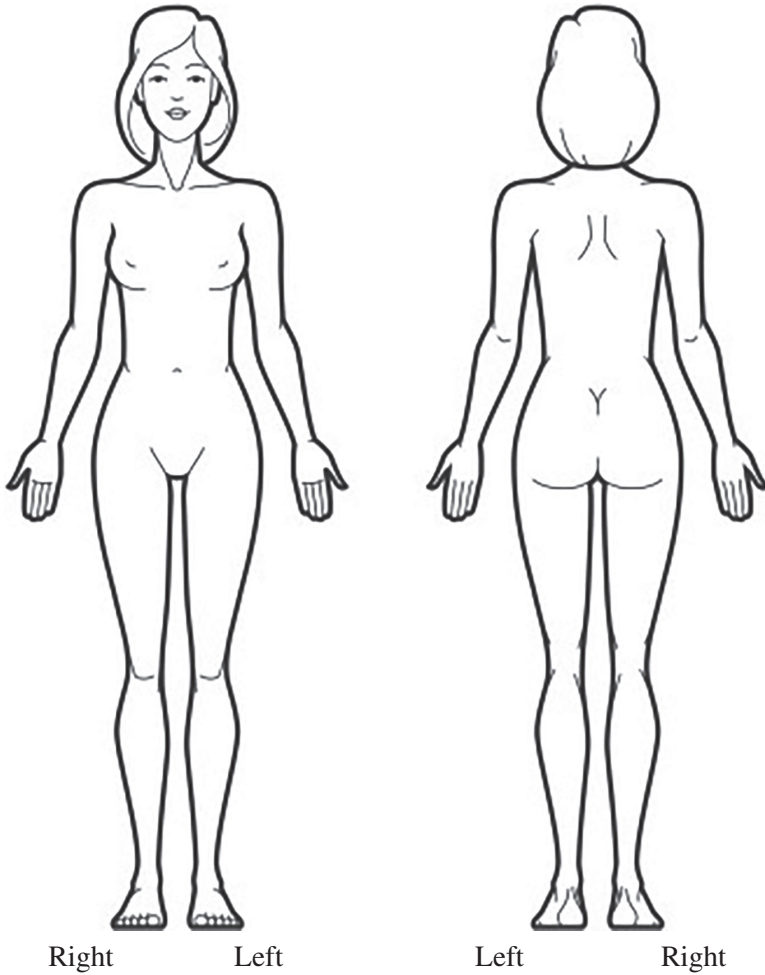
General	<input type="checkbox"/> fevers/chills	<input type="checkbox"/> flu-like	<input type="checkbox"/> dizziness	<input type="checkbox"/> weakness/excessive fatigue	
	<input type="checkbox"/> increase or decrease in appetite	<input type="checkbox"/> weight loss ____ lbs, in how much time _____			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

**Continue and complete pages 8 and 9 if you are being evaluated for Pelvic Pain.
 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 all the areas of your body where you feel pain. If there is an area that hurts more than anywhere else, put an X on that area.

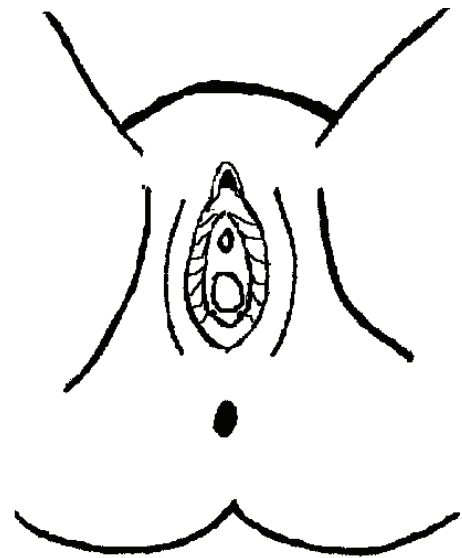


Vulvar / Perineal Pain

(pain outside and around the vagina and rectum)

If you have vulvar pain, shade the painful areas.

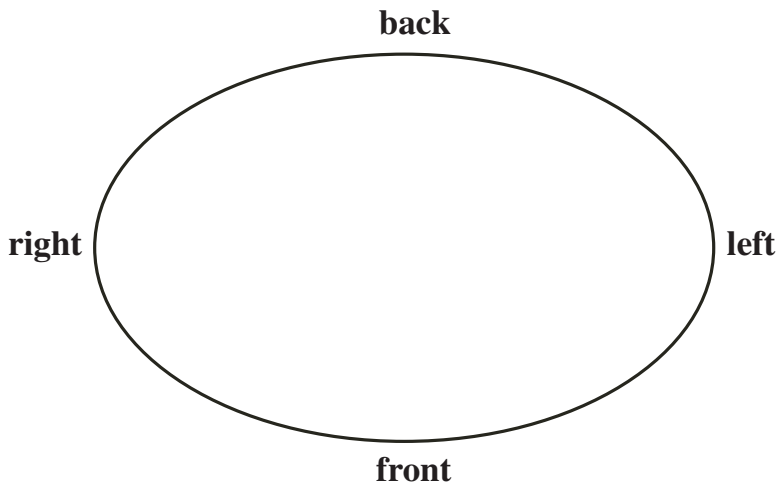
Is your pain relieved by sitting on a commode seat? Yes No



Please circle your level of pain below.

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

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



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

Patient initial _____

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

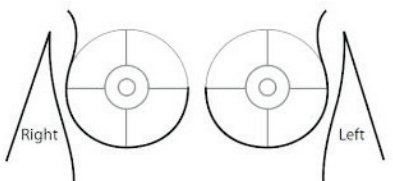
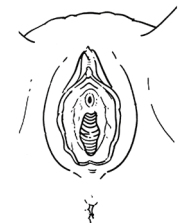
GASTROINTESTINAL (Comprehensive exam requires all bulleted items)
 • Abdominal Soft, non-tender Abnormal
 • Hernia None Abnormal
 • Liver/Spleen
 Liver Normal Abnormal
 Spleen Normal Abnormal
 • Stool guaiac indicated No Yes/Result _____

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(1-3)	N/A	N/A
Expanded Problem Focused 01	Required	Brief(1-3)	N/A	Problem Pertinent (1)
Detailed 01	Required	Extended (4+)	Complete (3)	Complete (3)
Comprehensive 04	Required	Extended (4+)	Complete (3)	Complete (10)