SAVANNAH

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PLEASE FILL THIS FORM OUT IN ITS ENTIRETY

Patient Name:______________________________ Date:______________

Marital Status:____________ DOB:____________ Age:______________

Occupation:____________ Did someone refer you?______ If so, who?____________

Have you ever seen Dr. Stubbs before?______ If yes, when and why?____________

Describe as thoroughly as possible the reason for today's visit. Include all symptoms, how long you have experienced them and indicate whether they are better, worse or remained the same.

____

____

Menstrual History (Skip this section if you are menopausal or have had a hysterectomy)

Age at first period: ________ Date of last period: ___/___/___ Date of previous period: ___/___/___

Interval between periods (first day menses to first day of next menses): ______ Days

Length of period (number of days bleeding each month):______ Days

Do you have irregular periods? ☐ No ☐ Yes

Is the bleeding heavy? ☐ No ☐ Yes

Usual number of pads/tampons used on heaviest day:______ Pads or tampons: ________

Cramps: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Medicine used for cramps:______________________________

Menopausal History (If not menopausal, skip to the next section)

Age of Menopause:__________ Bleeding since menopause? ☐ No ☐ Yes

Are you on any hormones? ☐ No ☐ Yes If yes, when did you start?____________

Have you ever been on hormones? ☐ No ☐ Yes

If yes, when, for how long, and why did you stop?______________________

____

Gynecologic History

Date of last Pap smear?___/___/___ ☐ Normal ☐ Abnormal

Have you ever had an abnormal Pap smear? ☐ No ☐ Yes When?____________

If yes, what was done?______________________________

Have you had a Hysterectomy? ☐ No ☐ Yes Why? ____________

Date of last mammogram:___/___/___ ☐ Normal ☐ Abnormal

Have you ever had an abnormal mammogram? ☐ No ☐ Yes When?____________

If yes, what was done?______________________________

Gynecologic History continued

Are you currently sexually active? ☐ No ☐ Yes Have you been sexually active in the past? ☐ No ☐ Yes

Total number of sexual partners in the last year? _____ Total number of sexual partners in lifetime? ______

Have you had, or do you have:	No	Yes	Explain
Fibroids	☐	☐	______
Endometriosis	☐	☐	______
Infertility	☐	☐	______
Any Pelvic Infections	☐	☐	______
Pelvic Inflammatory Disease (PID)	☐	☐	______
Gonorrhea	☐	☐	______
Chlamydia	☐	☐	______
Syphilis	☐	☐	______
HPV of Venereal Warts	☐	☐	______
Herpes	☐	☐	______
HIV or AIDS	☐	☐	______
Trichomoniasis	☐	☐	______
Bacterial Vaginosis	☐	☐	______
Cancer of the: Breast	☐	☐	______
Ovary	☐	☐	______
Uterus	☐	☐	______
Cervis	☐	☐	______
Fibrocystic breast changes	☐	☐	______
Are you currently having:			
Problems with Mesh	☐	☐	______
Frequent urination	☐	☐	______
Urinary urgency	☐	☐	______
Incomplete bladder emptying	☐	☐	______
Pain with urination	☐	☐	______
Blood in urine	☐	☐	______
Frequent bladder infections (UTIs)	☐	☐	______

Do you urinate more than once a night? ______ How many times? ______

Do you leak urine? ______ How long (weeks, months, years)? ______

What causes you to leak urine? ______
(laughing, coughing, sneezing, running, extreme urgency, other)

Do you use anything for protection from leakage of urine? ______
(pads, panty liners, tissue, Depend undergarments, dark clothing)

If yes, what and how many each day? ______

Have you ever had your leakage treated? ______ How? ______

Do you leak stool? ______

Do you have prolapse or dropping of your bladder, uterus or rectum? ______

Which? ______

Have you ever had your prolapse treated? ______ How? ______

Gynecologic History continued

What contraception do you use? (How do you prevent pregnancy) ______________________

Please list all forms of contraception you have used in the past. ______________________

____

Have you had any complications from using any forms of contraception? Which ones and what happened?

____

Obstetrical History (Please list each pregnancy and the requested information)

Total Pregnancies ________ Term Births ________ Preterm (<5lb, 9oz) ________ Living Children ________

Miscarriages ____________ Abortions ____________ Ectopics (Tubal pregnancy) ____________

Date	Wks. Gestation	Vaginal or C-Section	Weight of Baby	Male | Female	Complications

Have you had, or do you have:	No	Yes	Explain
Thyroid problems	☐	☐	______________
Diabetes	☐	☐	______________
Asthma	☐	☐	______________
Blood Clots	☐	☐	When?__________
High Blood Pressure (hypertension)	☐	☐	______________
Heart Problems	☐	☐	Which?__________
High Cholesterol (hyperlipidermia)	☐	☐	______________
Ulcer Disease	☐	☐	______________
Hepatitis	☐	☐	______________
Irritable Bowel Syndrome	☐	☐	______________
Kidney Stones	☐	☐	______________
Seizures	☐	☐	______________
Stroke	☐	☐	______________
Anemia (low blood count)	☐	☐	______________
Blood Clotting Disorder	☐	☐	______________
Previous Blood Transfusion	☐	☐	Why?__________
Sickle Cell Disease	☐	☐	______________
Arthritis	☐	☐	______________
Other medical problems	☐	☐	______________

Do you object to having blood or blood products?______________________

Last colonoscopy: ______________ Findings: ______________________

Who is your Primary Care Provider? ______________________

Surgical/Hospitalization History

Date	Illness or Operation	Hospital/Physician	Complications

Medication Allergies

Medication	Reaction

Current Medication (Please include all over-the-counter and non-prescription drugs)

Drug	Dosage	Frequency

Social History

	No	Yes	How Much/How Often
Do you smoke cigarettes?	☐	☐	________
Do you drink alcohol?	☐	☐	________
Do you exercise?	☐	☐	________
Do you perform self breast exams?	☐	☐	________
Recreational drug use?	☐	☐	________

Review of Systems

General	No	Yes	Explain
Recent changes in weight	☐	☐	
Fever or chills	☐	☐	
Frequent night sweats	☐	☐	
Tiredness or fatigue	☐	☐	
Neurological			
Headaches/migraines	☐	☐	______
Respiratory			
Shortness of breath	☐	☐	______
Chronic cough	☐	☐	______
Hematological			
Easy bruising	☐	☐	______
Prolonged bleeding	☐	☐	______
Eyes, Ears, Nose, Throat			
Visual problems	☐	☐	______
Hearing problems	☐	☐	______
Cardiovascular			
Limited exercise tolerance	☐	☐	______
Chest pain or discomfort	☐	☐	______
Palpitations	☐	☐	______
Gastrointestinal			
Frequent vomiting	☐	☐	______
Blood in stools	☐	☐	______
Frequent heartburn/indigestion	☐	☐	______
Frequent abdominal pain	☐	☐	______
Diarrhea	☐	☐	______
Constipation	☐	☐	______
Skin			
Moles that are changing	☐	☐	______
New moles	☐	☐	______
Musculoskeletal			
Joint stiffness	☐	☐	______
Joint pain	☐	☐	______
Joint swelling	☐	☐	______
Psychological			
Anxiety or panic attacks	☐	☐	______
Depression	☐	☐	______

IMPORTANT: You will need to address all your medical issues and concerns with your Primary Care Provider.

Family History

Anyone in the family with: Which family member? ______________________

Heart disease	______________	Diabetes	______________
Sickle cell	______________	Birth defects	______________
Colon cancer	______________	Hypertension	______________
Breast cancer	______________	Psychiatric disorder	______________
Ovarian cancer	______________	Clotting disorder	______________
Other cancers (type)	______________	Tuberculosis	______________

OFFICE USE ONLY

Ba ______________________

GH ______________________

Bp ______________________

PB ______________________

C ______________________

TVL ______________________

Hypermobility: YES NO

Stress Incontinence: YES NO

Supine Standing

Introitus: Gaping

Mildly Gaping

Nongaping

Reflexes: BC: ______________________

AW: ______________________

Atrophic: YES NO

RC: YES NO