Melinda Miller-Thrasher, MD
Janice Hull, NP
Sonya Wallace, NP
Wilhamina Bailey, PA

Innovative Women's HealthCare Solutions
Patient *centered.* Patient *driven.* Patient *empowered.*

3200 Highlands Pkwy SE Suite 420
Smyrna, GA 30082
678) 424-1123
www.iwhcs.com

Return Patient to Practice Questionnaire Gynecology

Welcome back to Innovative Women's HealthCare Solutions!

Patient Name:_____Age:_____DOB:_____Date: _____

Reason for visit: Annual exam Problem visit _____

Dr. Miller-Thrasher successfully completed a cosmetic surgery fellowship. Please check any concerns and procedures or products of interest to you so that we can better serve you today.

□ Liposuction/Liposculpture	□ Scar Revision/ Beautification	□ Micro-dermabrasion
□ Panniculectomy (removal of excess skin)	□ Snapback Package	□ Hyperpigmentation
□ Tummy Tuck	□ Injectable Fillers/Botox	□ Chemical Peels
□ BBL ("Booty Pop")	□ Gynecomastia (man boobs)	□ Uneven Skin Tone
□ Vaginoplasty/Labiaplasty	□ Wrinkles	□ Mole Removal
□ Vaginal Tightening	□ Skin Care Products	□ Enlarged Pores/ Acne Scarring
□ Breast Augmentation	□ Laser Hair Removal	□ Hair Loss Treatment
□ Fat Transfer (face/breasts)	□ Microneedling	□ Botox/Fillers
□ Mommy Makeover	□ Weight-loss	□ O Shot/P Shot
□ Scarless Breast Lift/Reduction	□ Split Earlobe Repair	□ Other

MENOPAUSAL SYMPTOM CHECKLIST- (circle if you are having any of the following problems):

***Decreased sex drive**	***Increased anxiety**	***Vaginal dryness**
***Difficulty achieving orgasms**	***Irritability/mood changes**	***Hair loss/thinning**
***Depressed mood**	***Weight gain/loss**	***Dry & wrinkled skin**
***Sleep Problems**	***Hot flashes/night sweats**	***Memory loss/confusion**

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Established Patient Follow-Up Questionnaire- Gynecology

Name:_____ DOB: _____ Date: _____

Chief reason for today's visit: Annual Exam? □ Problem Visit? □ _____

First day of last menstrual period: _____

Do your cycles come monthly? ? **Y N** If not, How often? _____Cycles last _____# of days

Are you currently pregnant? **Y N** If so, on what date was first positive pregnancy test? _____

Type of birth control currently using: _____

- (including none, vasectomy, tubal ligation, condoms, withdrawal, IUD, abstinence, Oral Contraceptive Pill, Nuvaring, Nexplanon, female partner, or natural family planning methods)

Do you use medication on a regular basis, including Medications/Supplements/Vitamins? Please list name and dose of medication: _____

Do you need refills on your medications? If so, which ones? _____

Are you interested in testing for Sexually Transmitted Infections today? **Yes** □ **No** □

Date of last pap smear: _____Results: _____

Have you had abnormal pap smears (what abnormality and when)? _____

If yes, circle the following: **HPV, Genital warts, Gonorrhea, Herpes, HIV, Syphilis, Hepatitis**

Have you been diagnoses or treated for any of the following conditions (if yes, circle): **uterine fibroids, uterine polyps, endometriosis, ovarian cysts, PCOS, infertility, breast cyst/mass, other?**

Have you ever received the Gardasil Vaccine (to prevent HPV and cervical cancer)? **Yes or No** _____# doses

Have you had gynecological or cosmetic surgery since your last visit? ? **Y N** If so, on what date and what surgery?_____

REVIEW OF SYSTEMS- *circle* if you are having any of the following problems:

Skipping periods	Abnormal vaginal discharge	Painful periods	Recurrent UTI	Vaginal dryness	Blood in your stools
Heavy vaginal bleeding	Vaginal odor	Painful intercourse	Blood in your urine	Breast pain	Depressed mood
Bleeding between periods	Recurrent vaginal infections	Pelvis mass	Pelvic pressure	Breast mass	Increased anxiety
Bleeding after menopause	External genital itching	Difficulty getting pregnant	Pelvic bulge or prolapse	Nipple discharge	Irritability
Bleeding after intercourse	External genital lump/lesion	Urinary frequency	Bothersome menopause symptoms	Chronic constipation	Unexplained weight changes
Anemia	Pelvic pain	Urinary leakage	Significant hot flashes	Chronic diarrhea	Fever or chills
		Pain with urination		Persistent nausea or vomiting	