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

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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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Last Menstrual Period _____

Do cycles come monthly? Yes No If not, how often? _____ Cycles last_____# days

Have you been pregnant since your last visit? Yes No

Current birth control: None, Condoms, Withdrawal, Birth Control Pills, IUD, Nuvaring, Nexplanon, Tubal sterilization, Vasectomy, Female Partner, Other:

_____

Current Medications: _____

_____

Which medications need refills? _____

Are you interested in testing for Sexually Transmitted Infections today? (STDs/STIs) Yes or No

Have you ever had an abnormal pap test? Yes No When? _____

What was follow-up? Repeat testing, colposcopy (with biopsy), LEEP/conization procedure, cryotherapy

Have you recently been treated for a Sexually Transmitted Disease (STD)? Yes No When? _____

If yes, circle/fill in: HPV, Genital warts, Chlamydia, Gonorrhea, Herpes, HIV, Syphilis, Hepatitis C

Have you had gynecologic surgery since your last visit? Yes No

Please list surgery: _____

Have you ever received the Gardasil Vaccine (to prevent HPV and cervical cancer)? Yes or No____# doses

Review of Systems: Circle if you are currently having any of the following problems?

Skipping periods, heavy vaginal bleeding, bleeding in between your periods, bleeding after menopause, bleeding after intercourse, anemia, abnormal vaginal discharge, vaginal odor, recurrent vaginal infections, external genital itching, external genital lump/lesion, pelvic pain, painful periods, painful intercourse, pelvic mass, difficulty getting pregnant, urinary frequency, urinary leakage, pain with urination, recurrent urinary tract infections, blood in your urine, pelvic pressure, pelvic bulge or prolapse, bothersome menopause symptoms, significant hot flashes, vaginal dryness, breast pain, breast mass, nipple discharge, chronic constipation, chronic diarrhea, persistent nausea or vomiting, blood in your stools, depressed mood, increased anxiety, irritability, unexplained weight changes, fever or chills.

Last Pap_____Mammogram_____Bone Density_____Colonoscopy _____

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