

SOUTHEAST COSMETIC GYNECOLOGY

Robert L. Harris, MD • Steven E. Speights, MD
Fellowship-Trained in Urogynecology & Reconstructive Vaginal Surgery

G-SHOT® Patient Information

Date: _____

General Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Social Security Number: _____ Date of Birth: _____

How did you hear about us? _____

Medical Information:

Past Medical History:

Please check any problems below that you have had, or are currently experiencing:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Acid Reflux / Heartburn | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Exposure to HIV/AIDS | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Lung Disease (COPD) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lupus Erythematosus | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Pancreatitis | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pulmonary Embolus | <input type="checkbox"/> Ovarian Cancer |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Rash | <input type="checkbox"/> Endometrial Cancer / |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Interstitial Cystitis | <input type="checkbox"/> Raynauds | Uterine Sarcoma |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Other Cancer |

Other: _____

Past Surgical History:

Please check all previous surgeries you have had:

- | | | |
|---|--|---|
| <input type="checkbox"/> Abdominal Hysterectomy | <input type="checkbox"/> Gall Bladder Surgery | <input type="checkbox"/> Paravaginal Repair |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Heart By-Pass Surgery | <input type="checkbox"/> Rectocele Repair |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Removal of Ovaries |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Heart By-Pass Surgery | <input type="checkbox"/> Sling Procedure |
| <input type="checkbox"/> Bladder Suspension | <input type="checkbox"/> Hernia Surgery | <input type="checkbox"/> Thyroid Surgery |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Tummy Tuck |
| <input type="checkbox"/> Cystocele Repair | <input type="checkbox"/> Lung Surgery | <input type="checkbox"/> Vaginal Hysterectomy |
| | <input type="checkbox"/> Lumpectomy | <input type="checkbox"/> Other Cancer Removal Surgery |

Other: _____

Current Medications:

Please list all medications you are currently taking:

Allergies:

Please list any allergies you have:

Medication Allergies:

Food Allergies:

Environmental Allergies: