JACK W. TUBBS, JR., M.D.

ASSOCIATES IN OBSTETRICS & GYNECOLOGY

DIANE LINK, RNC, NP
LASTENIA RYAN, MSN, WHNP-BC

PATIENT HEALTH UPDATE

Name_____ **Date**_____

Date of last menstrual period:_____

How Long is it from the start of one period to the start of the next?_____

How many days does your period last?_____

Do you use tampons (super or regular) and/or pad (light or heavy)?_____

How often do you change your pad or tampon on your heaviest day?_____

Are you interested in a simple in office procedure to control your periods?_____

What form of birth control do you use?_____

Are you interested in permanent birth control?_____

Any Illnesses or Surgeries since your last visit?_____

Current medications and dosages (include over the counter, vitamins, herbs, supplements):

_____

Do you have problems with:	**YES**	**NO**
Bleeding in between periods	_____	_____
Pain with your periods	_____	_____
Spotting after intercourse	_____	_____
Pain with intercourse	_____	_____
Vaginal discharge or odor	_____	_____
Urinary Incontinence	_____	_____
Bowel problems	_____	_____
Do you have pelvic pressure/prolapse?	_____	_____

Signature_____ Date:____/____/____

8580 SCARBOROUGH DRIVE, SUITE 100 COLORADO SPRINGS, CO 80920 PHONE: (719)596-3344 ~ FAX: (719) 632-6118