# BAPTIST HEALTH UROGYNECOLOGY CLINIC

**Name**: ________________________________________ **DOB**: _______________**SS#:** ___________________

**Race:** White / Black / Hispanic / Other: ____________

**Ethnicity**: Hispanic / Non-Hispanic

**Primary Language**: English / Spanish / Other: _____________

**Marital Status:** Single / Married / Divorced / Separated

**Religion:** Christian / Jehovah Witness / Christian Catholic / Other: _________

**Employment:** Full-time / Part-time / Unemployed / Student

**Work location: _____________________**

**Work phone: ______________________**

**Address: ____________________________City:____________________ State: ____ Zip code: _________**

**Primary Phone: ____________________________ Other: ________________________ Home/Cell**

**Email: ___________________________________ Primary Care Provider: _______________________**

**Emergency Contact: ______________________ Relationship: ____________ Phone: _________________**

***Guarantor Information (Person Responsible for Bill)***

**Name: ___________________________ Date of Birth: _____________ Sex: Female/Male**

**SS#: ______________________ Phone: _____________________ Relationship: __________________**

**Work Location: _________________________ Full-time/ Part-time**

***Insurance Information***

**Primary Insurance Carrier: ______________________________ Member ID: ________________________**

**Subscriber: _______________________ Subscriber DOB: ________________**

**Secondary Insurance Carrier: ____________________________ Member ID:________________________**

**Subscriber: _______________________ Subscriber DOB: _____________________________________**

***I give permission to BHUC to speak with the following individuals regarding my medical records (Lab results, insurance, appointments) if I am not available.***

**Name: _______________________________________________ Phone: ______________________**

**Name: _______________________________________________ Phone: ______________________**

***I certify that all of the above information is correct for billing purposes and it is my responsibility to notify BHUC of any changes to my information.***

**Patient Signature: ________________________________ Date: ________________________________**

**Name:** ______________________________________________**DOB:** ___________________________

**Current Allergies** (drug and environmental): _________________________________________________

**Medications** (please list both prescription and non-prescription medications you are currently taking):

| Medication | Dose | Times/Day | Medication | Dose | Times/Day |
|---|---|---|---|---|---|
| ___________ | ______ | _______ | ___________ | ______ | _______ |
| ___________ | ______ | _______ | ___________ | ______ | _______ |
| ___________ | ______ | _______ | ___________ | ______ | _______ |
| ___________ | ______ | _______ | ___________ | ______ | _______ |
| ___________ | ______ | _______ | ___________ | ______ | _______ |
| ___________ | ______ | _______ | ___________ | ______ | _______ |

**Current Pharmacy**: _______________________________________ **City**: _______________________

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**Obstetrical History:** ☐ Never been pregnant Total number of pregnancies ________
How many vaginal deliveries did you have? ____________ How many children do you have? _________

**Medical History: (circle all that apply)**
Diabetes High Blood Pressure Heart Disease Blood Disorder (clotting or bleeding)
Other: ____________________________________________________________________________

**Surgical History: (circle all that apply and include date if known)**
Removal of Uterus ________________ Removal of Ovaries__________
Past prolapse or incontinence surgery______________ Other: ___________________________________

**Sexual History:**
Age of onset of sexual activity: _________ Currently sexual active: Yes No
Do you use contraception: Yes No Type of contraception? _________________________________

**Family History: (circle illness which has occurred in any relative and write relationship to you)**
Diabetes: _________________ Heart Disease: ________________ Stroke: ________________________
Bleeding Disorder: ____________________ Cancer (type): ________________________________________
Seizures: _________________High Blood Pressure: _________________Thyroid Disease: ____________
Other: _______________________________________________________________________________

**Social History:**

| | | | |
|---|---|---|---|
| Do you drink Alcohol? | Yes | No | Amount per week: ___________________________ |
| Are you Sexually Active? | Yes | No | Birth Control: ________________________________ |
| Do you use drugs? | Yes | No | Type: ________________ Amount: ______________ |
| Do you use Tobacco? | Yes | No | Vapor Cigarettes Smokeless Tobacco |
| | | | Amount: _____________ Years Used: ____________ |

## BAPTIST HEALTH UROGYNECOLOGY CLINIC

**Name:** ______________________________________________**DOB:** ___________________________

**Referring Provider:** _________________________________

1. What is the reason for your visit? *(Check all that apply)*

   - ☐ Accidental bladder leakage
   - ☐ Recurrent bladder infections
   - ☐ Vaginal bulging (vaginal prolapse)
   - ☐ Problems with the vulva (e.g. pain, itch, skin problem)
   - ☐ Accidental bowel leakage
   - ☐ Painful intercourse
   - ☐ Problems emptying your bladder
   - ☐ Complication of previous pelvic surgery
   - ☐ Problems emptying your bowels
   - ☐ Pain related to your bladder, bowel or pelvic organs
   - ☐ Other

2. How long have you had your symptoms? *(Choose one best response)*

   - ☐ Less than 2 weeks
   - ☐ 3 – 4 Weeks
   - ☐ 5 – 8 Weeks
   - ☐ 9 - 12 Weeks
   - ☐ 4 – 6 Months
   - ☐ 7 – 12 Months
   - ☐ 1 – 2 Years
   - ☐ 2 – 3 Years
   - ☐ More than 5 years

3. How many different clinicians have you seen for your problem? *(Choose one best response)*

   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

*4.* Which kind of health care providers have you seen for your problem? *(Check all that apply)*

   - ☐ Primary Care Provider
   - ☐ Physical Therapist
   - ☐ Urologist
   - ☐ Obstetrician/Gynecologist
   - ☐ Pain Management
   - ☐ Other
   - ☐ Urogynecologist (subspecialist in female pelvic medicine and reconstructive surgery)

**Bladder Function:**

*1.* How many times do you urinate from the moment you wake until you sleep? _____/day *(Write in a whole number)*

2. How many times do you wake from sleep to urinate? ______/night *(Write in a whole number)*

3. How much caffeine (e.g. coffee, tea, soda) do you consume per day? *(Choose one best response)*

   ☐ None ☐ 1 – 2 Servings/day ☐ 2 – 4 Servings/day ☐ More than 4 Servings/day

4. Do you have a history of 3 or more bladder infections in the last 1 year (2 or more in the last 6 months)? *(Choose one best response)* ☐ Yes ☐ No

5. During the last 3 months, have you leaked urine (even a small amount)?
   ☐ Yes *(continue to question 6)* ☐ No *(Done – no UI. Skip to question 11)*

**Name:** _______________________________________________**DOB:** ___________________________

*6.* During the last 3 months did you leak urine *(Check all that apply):*

- ☐ When performing some physical activity, such as coughing, sneezing, lifting or exercise?
- ☐ When you had the urge or the feeling that you needed to empty your bladder, but you could not get to the toilet fast enough?
- ☐ Without physical activity and without a sense of urgency?

7. During the last 3 months, did you leak urine most often *(choose one best response):*

- ☐ When performing some physical activity, such as coughing, sneezing, lifting or exercise?
- ☐ When you had the urge or the feeling that you needed to empty your bladder, but you could not get to the toilet fast enough?
- ☐ Without physical activity and without a sense of urgency?
- ☐ About equally as often with physical activity as with a sense of urgency?

*8.* How often do you experience urinary leakage? *(Choose one best response)*

- ☐ Less than a few times a month (1)
- ☐ A few times a month (2)
- ☐ A few times a week (3)
- ☐ Every day and/or night (4)

*9.* How much urine do you lose each time? *(Choose one best response)*

- ☐ Drops (1)
- ☐ Small splashes (2)
- ☐ More (3)

10. How many pads do you use per day? ______/day *(Write in a whole number, if not leaking write "0")*

11. During the last 3 months, has your bladder sensation or function changed <u>during or following</u> urination?

- ☐ No
- ☐ Yes – *Check all the symptoms that apply*
  - ☐ Delay in initiating urination (1)
  - ☐ Slow stream (2)
  - ☐ Flow stop and start on more than one occasion during a void (3)
  - ☐ Straining to void (4)
  - ☐ Spraying (5)
  - ☐ Feeling of incomplete bladder emptying (6)
  - ☐ Need to immediately re-void (7)
  - ☐ Post void dribbling (8)
  - ☐ Position-dependent voiding (9)
  - ☐ Painful urination (10)
  - ☐ Inability to pass urine despite persistent effort (11)

**Name: _______________________________________________DOB: ___________________________**

**Sexual Function:**

12. Which of the following best describes you? *(Chose one best response)*
    □ Not sexually active *(complete question 13)* □ Sexually active

13. What are the reasons for your NOT being sexually active *(check all that apply)*
    - □ No partner (to include if partner is unable to have sex)
    - □ No interest
    - □ Due to bladder or bowel problems (leakage of urine or stool) or due to pelvic organ prolapse (a feeling of a bulge in the vaginal area)

    **Overall, how bothersome is it to you that you are NOT sexually active?**
    □ Not at all □ Somewhat □ Moderately □ Quite a bit

14. During the last 3 months, do you feel pain during sexual intercourse? (If you do not have intercourse, check this box □ and skip to the next question)
    If yes, how much does it bother you? □ Not at all □ Somewhat □ Moderately □ Quite a bit

15. During the last 3 months, do you feel that your vagina is too loose?
    If yes, how much does it bother you? □ Not at all □ Somewhat □ Moderately □ Quite a bit

**Name: ___________________________________________DOB: _________________________**

**Today's Date**: ______________________________

**Review of Systems**: *Please circle all that apply*

**General**: Fever, Chills, Fatigue, Weight Loss, Weight Gain
**ENT**: Sore Throat, Hearing Loss, Vision Loss, Chronic Cough
**Cardio**: Chest Pain, Palpitations, Swelling Legs
**Respiratory**: Cough, Shortness of Breath, Wheezing
**Endocrine**: Unexpected Weight Changes, Excessive Thirst, Hot Spells
**Heme-lymph**: Bleeding, Bruising, History of Transfusions
**Neuro**: Confusion, Memory Loss, Numbness, Tingling
**Musculoskeletal**: Back Pain, Joint Stiffness, Mobility Issues
**Emotional**: Depression, Anxiety, Other: ______________________________________________