Today's date: ________ Name____________________________ DOB_______ Age______

Insurance:

Reason for visit ______________________ How long have you had this problem?__________

Who referred you to see us? ________________ Name of PCP __________________ Gynecologist: _________________

Pharmacy Name:______________ City: ______________Street: __________________ Mail-Away __________________

Home phone ________________ Cell phone ________________ Texting OK ☐Y ☐ N

Email ______________________ Patient/HIE portal ☐Y ☐ N Healthcare Proxy ☐Y ☐ N

Medications & over the counter drugs (use a separate sheet if necessary)

1.___________________________________ 6. _____________________________ 11. ___________________________

2. __________________________________ 7. _____________________________ 12 ____________________________

3. __________________________________ 8 ._______________________________13 ____________________________

4. _________________________________ 9. ______________________________14 ____________________________

5. __________________________________10. ______________________________ 15 ____________________________

Ob-Gyn History:

pregnancies ___ # vaginal deliveries ___ # C-sections ___ Year of births: _______________ Last period _________

Menstrual cycle: ☐ not applicable ☐ regular ☐ irregular ☐ normal flow ☐ heavy ☐ light

☐ every 24-35 days ☐ <24 days ☐ >35 days

History of : ☐ endometriosis ☐ ovarian cysts ☐ fibroids ☐ infertility/ IVF ☐ recurrent vaginal infections

☐ other ____________

Menopause : ☐ not applicable ☐ post-menopausal bleeding date_______ ☐ hot flashes ☐ night sweats

☐ vaginal dryness ☐ painful intercourse ☐ lubricant use ☐ hormone therapy use

Sexually active ☐ Yes ☐ No Contraception ☐ No ☐ Pills ☐ IUD ☐ Mirena ☐ ____________

Date of last pap smear ________ Norrmal? ☐Y ☐N Abnormal Paps ? ☐Y ☐N Explain _______________

Date of last mammogram ________ Normal? ☐Y ☐N Abnormal mammograms? ☐Y ☐N Explain ______________

Medical History: (check all that apply)

☐ Arthritis ☐ Depression/Anxiety ☐ Blood Clots ☐ Hypothyroid ☐ Stroke/ TIA

☐ Asthma ☐ Diabetes ☐ COPD ☐ IBS ☐ Heart attack

☐ Atrial Fibrillation ☐ Fibromyalgia ☐ Herniated Disc ☐ Liver Problems ☐ Heart failure

☐ Pacemaker ☐ Acid Reflux ☐ High cholesterol ☐ Kidney Stones ☐ Diverticulosis

☐ Dementia ☐ Glaucoma ☐ Hypertension ☐ Sleep Apnea/CPAP

☐ Cancer type _______ ☐ Year _______ ☐ Chemo ________ ☐ Radiation ☐ Tamoxifen/Arimidex

☐ Other ____

Allergies: ☐ No Known Drug Allergies ☐ Sulfa ☐ Local anesthetics ☐ Penicillin ☐ Latex ☐ Other ______________

Surgical History: (circle all that apply) **Date of surgery**

☐ Hysterectomy Y N type: ☐ abdominal ☐ vaginal ☐ laparoscopic ___________

☐ Removal of ovaries Y N type ☐ both ☐ right ☐ left ___________

☐ Bladder surgery Y N type: ☐ sling ☐ suspension ☐ other ___________

☐ Prolapse surgery Y N type: ☐ cystocele ☐ rectocele ☐ other ___________

☐ Please check if you have had any of the following:

☐ angioplasty/stent ☐ C-Section ☐ gallbladder ☐ knee Replacement R/L ☐ hip replacement R/L

☐ appendectomy ☐ colon resection ☐ laparoscopy ☐ knee arthroscopy ☐ tonsillectomy

☐ back surgery ☐ endometrial ablation ☐ D&C ☐ hernia repair: groin, other ☐ tubal ligation

☐ other surgeries:____

Family History: Have any of your immediate relatives (parents, children, and siblings) had the following? Indicate who.

Urinary incontinence ☐Y ☐N ________ Prolapse ☐Y ☐N ________ Bladder cancer ☐Y ☐N ________

Other cancer ☐Y ☐N ________ Breast cancer ☐Y ☐N ________ Gynecologic cancer ☐Y ☐N ________

Other relevant history ____ Family history unknown ☐

Social History: ☐ Single ☐ Widow ☐ Partner ☐ Married ☐ Live at home ☐ Nursing home or Assisted living

Smoking ☐Y ☐N #packs/day: ___ #years: ____ Year quit: ____

Alcohol ☐Y ☐N ☐ <3 drinks/week ☐ <3 drinks/week

Currently working ☐Y ☐N type of work:_________

Regular exercise ☐Y ☐N how often: ___________ Drugs ☐Y ☐N how often: ________ ☐ type_______

REVIEW OF SYSTEMS: circle those that apply

GENERAL fever chills weight loss

ENT/EYE dry mouth dry eyes blurry vision

CARDIOLOGY palpitations chest pain leg swelling

PULMONARY cough shortness of breath

GI constipation diarrhea heartburn difficulty swallowing

GU blood in urine pain with urination

SKIN & BREAST bruise easily rash change in mole non healing ulcer

NEUROLOGY headache numbness tingling dizziness

PSYCHOLOGY depression anxiety moody

ENDOCRINE hot flashes night sweats excessive water intake

HEMATOLOGY swollen glands bleeding problems easy bruising

I authorize signing up for patient portal. ☐Y ☐N Reason: ☐ I do not have email ☐ I do not wish to disclose email

I authorize the practice to access my medical records through eLINC. ☐Y ☐N - This allows my provider to securely access my medical records electronically through the provider portal administered by Winchester Hospital, a member of Lahey. This is a physician organization that your primary care physician may already be a member.

I authorize practice to access my prescription drug information from the pharmacy database. ☐Y ☐N

Financial responsibility: I have requested medical services from New England Urogynecology (the practice) on behalf of myself and understand by making this request, I become fully financial responsible for any and all charges incurred in the course of the treatment authorized. I understand these fees are due and payable on the date that services are rendered and agree to pay all charges incurred in full, immediately upon presentation of the appropriate statement.

Assignment of Benefits: I hereby assign all medical and surgical benefits to New England Urogynecology. I authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payments directly to the practice for medical services rendered to myself. I understand that I am responsible for any amount not covered by insurance. Co-Payments, deductibles and past due balances are due at time of medical services. **Overdue accounts will be referred to a collection agency.** We accept Credit card, Checks, and Cash. Returned Check Fee is $35.00.

No Show Policy: We have a 48 hour cancellation policy. If you miss your appointment without notice we charge a $50.00 for visit and in case of procedure $70.00.

I hereby consent to the use and disclosure of information in my medical records for treatment, payment and health care operations purposes. I understand that information in my medical records may be used and disclosed to persons other than New England Urogynecology to carry out their responsibilities in connection with my medical treatment, in payment for health care services rendered to me and in activities related to health care operations. I acknowledge that I have been provided the New England Urogynecology Notice of Privacy Practices. My signature below acknowledges that I have read this policy, understand and agree to my consent for treatment and financial responsibility.

Patient Name:______________________ DOB: ___ Signature:_____________________ Date: _________

Primary Insurance Name ____________________________ ID # ____________________________

Secondary Insurance Name __________________________ ID # ____________________________

Name: ____________________ DOB: ________ Height: _____ Weight: _____ BP _____ Date of exam __________

Do you urinate frequently?	☐always	☐frequently	☐occasionally	☐rarely/never
Do you have urgency to urinate?	☐always	☐frequently	☐occasionally	☐rarely/never
How often do you urinate during the day?	☐4-6	☐6-8	☐10-12	☐>15
How often do you wake up to urinate during the night?	☐ 0	☐1-2	☐3-4	☐>4
How many cups of fluid do you drink in a day?	☐<8	☐8-10	☐>10	☐>15
How many cups of caffeine do you drink in a day? (this includes coffee, tea, sodas)	☐0	☐1-2	☐3-4	☐ >5

Do you have leakage of urine?	☐ rarely/never	☐daily	☐few times a week	☐few times a year		
Do you wear protection for incontinence?	☐ sometimes	☐always	☐exercising	☐travelling	☐never	
What type do you wear?	☐ panty-liners	☐pads	☐adult diapers	☐none		
How many pads per day?	☐1	☐2	☐3	☐4	☐5	☐>5
How would you describe leakage?	☐few drops	☐few teaspoons	☐soaks a pad	☐soaks clothing		
Medications used:	☐detrol	☐oxybutynin	☐vesicare	☐none	☐don't know	

Do you lose urine accidentally during any of the following activities? (check all that apply)

☐coughing ☐sneezing ☐laughing ☐exercising ☐ during day without knowing

☐ walking to toilet ☐hear water ☐cold weather ☐during sex ☐in sleep ☐suddenly without warning

Do you have any of these bladder symptoms?

☐ difficulty emptying bladder ☐ difficulty starting stream ☐ slow/weak urine stream

☐ pain with urination ☐ blood in urine ☐frequent urinary or bladder infections

☐straining to urinate ☐ bladder fullness or pressure

PVR: ________

Q tip ________

Ring/gelhorn:

Do you have vaginal pressure?	☐Always	☐Sometimes	☐Never
Do you feel something protruding from the vagina?	☐Always	☐Sometimes	☐Never
Do you have to push the vagina to urinate or move bowels?	☐Always	☐Sometimes	☐Never
Do you suffer from vaginal dryness or painful intercourse?	☐Always	☐Sometimes	☐Never

RISKS: (for office use)

How are your bowel movements?	☐Normal	☐Constipated	☐Diarrhea	☐Variable
Do you use laxatives or stool softeners?	☐Always	☐Sometimes	☐ Never	

Do you leak stool or gas accidentally during any of the following? (check all that apply)?

☐before reaching toilet ☐without warning ☐without knowing ☐with watery stools only

☐with normal stool

Please list some of the questions that you would like the doctor to answer today.

1.____

2.____

3.____

Plan:
estrace, premarin, estradiol QHS x ___, BIW/TIW
Pessary insertion
Meds:
Get records
Pelvic u/s
CT urogram
Cystoscopy
UDT CMG