PLEASE FILL OUT THE FRONT & BACK OF THIS FORM

Insurance:

Today's date: _____ Name_____ DOB_____ Age_____

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_____

Healthcare Proxy ☐ Y ☐ N Name & Phone of proxy _____

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

1. _____ 5. _____ 9. _____
2. _____ 6. _____ 10. _____
3. _____ 7. _____ 11. _____
4. _____ 8. _____ 12. _____

Allergies: ☐ None ☐ Sulfa ☐ Penicillin ☐ Local anesthetics ☐ Latex ☐ Other _____

OB- GYN history:

Pregnancies ___ # deliveries ___ # C-sections ___ Last delivery (yr) _____ last period_____ Postmenopause bleed ☐Y ☐N

Menstrual cycle:☐ n/a ☐Regular ☐Irregular ☐every 28-30 days ☐<21 days ☐>35 days ☐ Heavy ☐ Light ☐ Normal flow

Sexually active: ☐ Y ☐ N Contraception: ☐ Pills ☐ IUD_____ ☐Condoms Ttubal ligation ☐Vasectomy ☐other_____

Menopause: ☐n/a ☐Hot flashes ☐Night flashes ☐Vaginal dryness ☐Painful sex ☐Hormone therapy use

History of: ☐Infertility/IVF ☐Fibroids ☐Endometriosis ☐Ovarian cysts ☐Recurrent vaginal infection ☐other

Date of last Pap _____ Normal? ☐Y ☐N Abnormal Pap smears? ☐Y ☐N Explain _____

Date of last Mammogram _____Normal? ☐Y ☐N Abnormal Mammogram? ☐Y ☐N Explain _____

Medical History: [Check All That Apply]

☐ Breast cancer ☐ right ☐ left ☐year____ ☐ lumpectomy ☐ mastectomy ☐chemo ☐radiation ☐ Tamoxifen/Arimidex

☐ Blood clots ☐ lung ☐ legs ☐ year____ ☐ Diabetes ☐ Sleep apnea/CPAP ☐ COPD ☐ Glaucoma

☐ Rheumatoid arthritis ☐Aatrial fibrillation ☐ Pacemaker ☐ Dementia ☐ Depression/anxiety ☐ Asthma

☐ Stroke/TIA ☐ Heart attack ☐ Heart failure ☐ Acid reflux ☐ Herniated disc ☐ Chronic back pain

☐ Hypertension ☐ High cholesterol ☐ Hypothyroid ☐ IBS ☐ Liver problems ☐ fFbromyalgia

☐ other _____

_____

Surgical History: [Check All That Apply]

Hysterectomy : ☐Y ☐N (Reason: _____) Year_____ ☐ Removal of ovaries: R/ L Year: _____

Bladder surgery: ☐Y ☐N ☐ Sling for leakage☐ Prolapse repair Year_____ _____

☐ C-section #____ ☐ Endometrial ablation ☐ D&C ☐ Tubal ligation ☐ Hernia repair: ☐ groin R/L ☐ abdominal R/L

☐ Colon resection ☐ Angioplasty/stent ☐ Cardiac bypass ☐ Knee replacement R/L ☐ Hip replacement R/L

☐ Back surgery ☐ Appendectomy ☐ Gallbladder ☐ Breast: ☐ Biopsy ☐ Lumpectomy ☐ Mastectomy☐ R/L

☐ other _____

Family history:

Incontinence: ☐Y ☐N ☐mother ☐sister ☐daughter Prolapse: ☐Y ☐N ☐mother ☐sister ☐daughter

Gynecological cancer: ☐Y ☐N ☐mother ☐sister ☐daughter Breast cancer: ☐Y ☐N ☐mother ☐sister ☐daughter

Bladder cancer: ☐Y ☐N Other relevant family history: _____

Social History:

☐ Single ☐ Widow ☐ Married ☐ Partner☐ Live at home ☐ Nursing home or Assisted living ☐ Driving

Smoking: ☐ N ☐ Y #packs/day ___ # years:__ Year quit____ Alcohol: ☐ N ☐ Y <3 wk >3/wk type _____

Working: ☐ N ☐ Y type of work_____ Exercise ☐ N ☐ Y #/week ____ type: _____ Drugs:☐ N ☐ Y type _____

REVIEW OF SYSTEMS: circle those that apply

Constitutional	fever chills weight loss	**Skin**	bruise easily change in mole rash/ulcer
Eye	dry eyes blurry vision eye pain	**Neurology**	headache numbness tingling dizziness
ENT	dry mouth earache hearing loss	**Psychology**	sadness anxiety moodiness
Cardiology	palpitations chest pain leg swelling	**Endocrine**	hot flashes night sweats excessive thirst
Pulmonary	cough shortness of breath	**Hematology**	swollen glands bleeding problems easy bruising
GI	diarrhea constipation heartburn	**GU**	blood in urine pain vaginal discharge

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 of.

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 50.00.

No Show Policy: We have a 48hour cancellation policy. If you miss your appointment without notice we charge a $50.00 for visit and in case of procedure $100.00.

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 ☐7-9 ☐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? ☐ 0 ☐1-2 ☐3-4 ☐ >5
(this includes coffee, tea, sodas)

Do you have leakage of urine? ☐ Rarely/Never ☐ Daily ☐ Few times a week ☐ Few times a year
Do you wear pads 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 ☐ Myrbetriq ☐ none ☐ Other

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

How many urinary tract infections have you had in the last 1 year ☐<2 ☐2-4 ☐4-6 ☐ >6
Please check all that apply when you get an infection
☐ Pain with urination ☐ Fever/chills ☐ Frank blood when urinating ☐ Bladder pressure
☐ Urgency ☐ Triggered by sex Urine cultures are: ☐ Negative ☐ Positive

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

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._____

PVR: _____
Q tip _____
Ring/gelhorn:
PFM:

RISKS: (for office use)

Plan: f/u- 2w 4w 6w
estrace, premarin, estradiol QHS x ___, BIW/TIW
Cystoscopy 4w 6w
UDT CMG- 4w 6w
Pelvic u/s
CT urogram
Pessary insertion
Meds:
Get records