ILLINOIS UROGYNECOLOGY, LTD. REGISTRATION FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES

Name: Last	First	Maiden Name	Date of Birth	Age
Street Address		Single Married Divorced Widowed		
City	State	Zip	Ethnicity	
Home Phone Number	Cell Phone Number		Email address	

Employer	Occupation
Street Address	Are you a student? Yes No Full Time Part Time
City State Zip	Phone Number

Spouse Name	Date of Birth	
Spouse Employer	Spouse's Employer Phone Number	

Referring Physician	Family Physician
Street Address	Street Address
City State Zip	City State Zip
Phone Number	Phone Number

Pharmacy Name Address	Pharmacy Phone Number

Primary Insurance	Group Number	I.D. Number
Street Address	Name of Insured	Relationship
City State Zip	Phone Number	

Secondary Insurance	Group Number	I.D. Number
Street Address	Name of Insured	Relationship
City State Zip	Phone Number	

In Case of Emergency, Notify	Relationship	Phone Number

Signature: _____ Date: _____

UROGYNECOLOGY-Patient History
Please complete this form as completely as possible

Who referred you to our practice? (check one):

___doctor ___nurse ___family ___friend ___other

Name of person making referral: _____

Name of your primary physician: _____

Name of your gynecologist: _____

What is the reason for your visit to our practice?
Please describe your symptoms in detail including when they started and how long they have been occurring

_____

_____

_____

_____

_____

Have you had any prior treatments for this problem?
Yes / No Treatment (please circle all that apply):

___/___ **Pessary**:
Using now; Used in the past; Tried but unsuccessful

___/___ **Pelvic Floor Physical therapy** such as:
Biofeedback, Electrical stimulation

___/___ **Medications** for Overactive Bladder such as:
Oxybutinin, Ditropan, Oxytrol patch, Detrol, Sanctura, Vesicare, Enablex, Toviaz, Gelnique

___/___ **Medications** for Bladder Infections such as:
Bactrim, Septra, Cipro, Macrodantin, Keflex

___/___ **Medications** for IC or Pelvic Pain such as:
Elmiron, Urelle, Prosed Pyridium, Elavil, Bladder Instillations, Accupuncture

___/___ **Surgery** for Incontinence such as:
MMK, Burch, Sling procedure, TVT, TOT, Collagen injection, bladder lift

___/___ **Surgery** for Pelvic Prolapse such as:
Hysterectomy, Anterior Repair, Posterior Repair, Cystocele repair, Rectocele repair, Sacrocolpopexy, Vaginal Mesh procedure

___/___ Other treatments: _____

_____

_____

_____

GYNECOLOGIC HISTORY

Total number of pregnancies: _____
Number of living children: _____
Number of vaginal deliveries: _____
Number of C-sections: _____
Miscarriages or Abortions: _____
Weight of largest baby: _____
Age when your periods started: _____

Date of last Pap Smear: _____
Date of last Mammogram: _____

Name: _____

Age: _____ Date of Birth: ____/____/____

What is your occupation: _____

GYNECOLOGIC HISTORY--continued

Yes/No

___/___ I still have regular periods
If yes, Date last period started: _____

___/___ I am currently using birth control
If yes, Type of birth control: _____

___/___ I have had a hysterectomy

___/___ I have had my ovaries removed

___/___ I have entered menopause

___/___ I am currently taking estrogen/hormone therapy
If yes, Type of hormone therapy: _____

URINARY FUNCTION QUESTIONNAIRE

Yes / No

___/___ I feel a bulge or protrusion in the genital area

___/___ I lose urine when I cough, sneeze or laugh

___/___ I lose urine when standing up from a sitting position

___/___ I sometimes leak urine on the way to the bathroom

___/___ I get up at night to urinate
How often?
___1 time ___2 times ___3 times ___4 times

___/___ I sometimes wet the bed

___/___ I have to empty my bladder frequently during the day
How often?
___ more than every hour
___ every 1-2 hours
___ every 2 hours
___ every 2-3 hours

___/___ I feel like my bladder is not empty after I urinate

___/___ I sometimes have to strain or push to empty my bladder

___/___ I have pain when my bladder is full

___/___ I have burning or pain while I am urinating

___/___ I have pain after urinating

___/___ I have difficulty controlling bowel movements

___/___ I have difficulty controlling gas from the rectum

___/___ I move my bowels every day

___/___ I have difficulty with constipation

___/___ I usually have to strain to move my bowels

___/___ I have to wear protection because of leakage
What type of protection?
___Light pad ___Heavy pad ___Diaper

How many pads or diapers each day? _____

How many pads or diapers at night? _____

___/___ I avoid activities because I'm afraid of leaking

___/___ I avoid activities because of bulging in the vagina

___/___ I avoid activities because of pain or discomfort

SEXUAL FUNCTION QUESTIONNAIRE

Yes/No

___/___ I am currently sexually active

___/___ I have pain during intercourse

___/___ I have urinary leakage during intercourse

___/___ I avoid sexual activity because I'm afraid of leaking

___/___ I avoid intercourse because of bulging in the vagina

MEDICAL HISTORY

Do you have any of the following medical problems?

Yes/No Comments:

Vision/Hearing problems
___/___Impaired vision
___/___Glaucoma
___/___Hearing difficulties
Lung/Respiratory problems
___/___Asthma
___/___Emphysema or COPD
___/___Sleep apnea
Heart/Cardiovascular Problems
___/___Coronary Artery Disease
___/___Heart arrhythmia
___/___High blood pressure
___/___Stroke
Cardiac procedures:
___/___Cardiac stress test
___/___Angiogram
___/___Angioplasty/Stent placement
Diabetes/Endocrine Problems
___/___Diabetes
___/___Thyroid problems
Bleeding issues/Hematology Problems
___/___Anemia
___/___Bleeding tendency
___/___Blood clots
___/___Treatment with blood thinners
Joints/Musculoskeletal Problems
___/___Arthritis
___/___Fibromyalgia
___/___Lupus
Neurologic Problems
___/___Seizures
___/___Multiple Sclerosis
Liver/Gastrointestinal Problems
___/___Ulcers
___/___GERD/reflux disease
___/___Hepatitis
___/___Diverticulosis
___/___Irritable bowel syndrome
Psychiatric Issues
___/___Anxiety disorder
___/___Depression
Cancer
___/___Breast Cancer
___/___Other Cancer: _____

___/___Any other medical problems (please list):

_____

_____

FAMILY HISTORY

Yes/No
___/___Heart disease
___/___High blood pressure
___/___Diabetes
___/___Breast cancer
___/___Gynecologic cancer
___/___Stroke
___/___Bleeding problems
___/___Other problems:

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Name: _____

SOCIAL HISTORY

Yes/No
___/___ Never smoked
___/___ Former smoker
___/___ Current smoker; _____packs/day
___/___ Never drink alcohol
___/___ Occasionally drink alcohol
___/___ Often drink alcohol
___/___ Use recreational drugs
___/___ Use herbal supplements

REVIEW OF SYSTEMS

Do you have any of the following symptoms today?

Yes/No comments
___/___Fever or chills
___/___Unwanted weight loss
___/___Blurred vision
___/___Ear infection
___/___Sore throat
___/___Chest pain
___/___Palpitations
___/___Shortness of breath
___/___Coughing
___/___Wheezing
___/___Abdominal pain
___/___Nausea/vomiting
___/___Diarrhea
___/___Joint pain
___/___Skin rash
___/___Dizziness
___/___Numbness or tingling
___/___Excessive thirst
___/___Easy bruising
___/___Feeling anxiety
___/___Feeling depressed

_____

What are your goals of treatment?

_____

_____

_____

_____

_____

_____

_____

Today's date: _____/_____/_____

For office use only

Scanned into EMR (as "Initial History" in Documents):
Date: _____/_____/_____ Initials _____
Entered into EMR (Summary Section):
Date: _____/_____/_____ Initials _____

Name:_____

Age:_____ Date of Birth: ____/____/____

Date of visit: ____/____/____

Do you have any **ALLERGIES to Medications**? ___Yes ___No *If yes, please list and describe the reaction*

Medication you are allergic to *Reaction (skin rash, difficulty breathing, etc)*

List your **MEDICATIONS** including the dose you take, the reason for taking each medication, and which doctor prescribed the medication for you; List any non-prescription (over-the-counter medications) you take at the bottom

Medication *Dose* *Reason for taking* *Doctor who prescribed*

Non-prescription Medications:

PREVIOUS SURGERY AND HOSPITALIZATIONS Please list the type of surgeries you've had; and the date , hospital and surgeon; include procedures such as cardiac catheterization, angioplasty, stent placement, etc.

Surgery/Procedure *Date/Year* *Hospital* *Surgeon*