Associates in Urogynecology

BLACK INK ONLY

PATIENT INFORMATION SHEET

PATIENT INFORMATION:		
Last Name:	First Name:	Date of Birth:
Address:	City:	State: Zip:
Home Phone:	Cell Phone:	
E-Mail Address:		
Employer:	Occupation:	Work Phone:
Social Security Number:		
Primary Language:	Ethnic Origin:	Race:
EMERGENCY CONTACT INFORMATION:		
Name:	Relationship:	Phone:
PRIMARY INSURANCE:		
POLICY HOLDER		
Last Name:	First Name:	Date of Birth:
Address:	City:	State: Zip:
Relationship to Patient:	Social Security Number:	
Employer:	Employer Phone Number:	
Address:	City:	State: Zip:
Insurance Name:		
Address:	City:	State: Zip:
Insurance ID#:	Group #:	
SECONDARY INSURANCE:		
POLICY HOLDER		
Last Name:	First Name:	Date of Birth:
Address:	City:	State: Zip:
Relationship to Patient:	Social Security Number:	
Employer:	Employer Phone Number:	
Address:	City:	State: Zip:
Insurance Name:		
Address:	City:	State: Zip:
Insurance ID#:	Group #:	

Associates in Urogynecology
70 West Gore Street, Suite 201
Orlando, FL. 32806-1124

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PATIENT INFORMATION SHEET

MEDICAL PROVIDER INFORMATION:			
Name:			
Primary Care Physician:			
Address:	City:	State:	Zip:
Phone Number:	Fax Number:		
Referring Physician:			
Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Signature:_____

Date:_____

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PATIENT QUESTIONNAIRE

Date of Appointment: _____

Last Name: _____ First Name: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Number of Pregnancies: _____ Number of Vaginal Births: _____ Number of C-Sections: _____

Weight of Largest Baby: _____ Form of Birth Control: _____ Date LMP: _____ Age at Menopause: _____

Do you smoke? ☐ yes ☐ no _____packs per day Do you drink alcohol? ☐ yes ☐ no _____drinks per day

Listed below are a series of questions regarding your bowel, bladder or pelvic symptoms, as well as your degree of discomfort, if any. Using the "key" - in the gray box - please place an **X** next to the appropriate number for each question below. While answering these questions, please consider your symptoms **over the last 3 months**.

KEY:
1 - Not at All
2 - Somewhat
3 - Moderately
4 - Quite a Bit

1. Do you experience pressure in the lower abdomen? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

2. Do you experience heaviness or dullness in the pelvic area? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

4. Do you have to push on the vagina or rectum to complete a bowel movement? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

5. Do you experience a feeling of incomplete bladder emptying? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

6. Do you have to push up on a bulge in the vaginal area to start/complete urination? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

7. Do you feel you need to strain too hard to have a bowel movement? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

8. At the end of a bowel movement, do you feel you have not completely emptied your bowels? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

9. If your stool is well formed, do you lose stool beyond your control? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

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Name:_____

Date:_____

KEY:
1 - Not at All
2 - Somewhat
3 - Moderately
4 - Quite a Bit

10. If your stool is loose or liquid, do you lose stool beyond your control? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

11. Do you lose gas from the rectum beyond your control? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

12. Do you have pain when you pass your stool? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

14. Does a part of your bowel ever pass through your rectum and bulge outside, during, or after a bowel movement? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

15. Do you usually experience frequent urination? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

16. Do you experience urine leakage associated with a strong sensation of needing to go to the bathroom? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

17. Do you experience urine leakage related to coughing, sneezing, or laughing? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

18. Do you experience small amounts of urine leakage (that is drops)? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

19. Do you experience difficulty emptying your bladder? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

20. Do you experience pain or discomfort in the lower abdomen or genital region? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

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QUALITY OF LIFE ASSESSMENT

Last Name:_____ First Name: _____

Age:_____ Date of Birth:_____ Height:_____ Weight:_____

Some women find that bladder, bowel or vaginal symptoms affect their activities, relationships, and feelings. Place an ***X*** in the response that best describes *how much* your activities, relationships or feelings have been affected **by your bladder, bowel or vaginal symptoms over the past 3 months**.

How do symptoms or conditions related to the following usually affect your...

Ability to do household chores (cooking, housecleaning, laundry)?

Bladder or urine	Bowel or rectum	Vagina or pelvis
☐ Not at all	☐ Not at all	☐ Not at all
☐ Somewhat	☐ Somewhat	☐ Somewhat
☐ Moderately	☐ Moderately	☐ Moderately
☐ Quite a bit	☐ Quite a bit	☐ Quite a bit

Ability to do physical activities such as walking, swimming, or other exercise?

Bladder or urine	Bowel or rectum	Vagina or pelvis
☐ Not at all	☐ Not at all	☐ Not at all
☐ Somewhat	☐ Somewhat	☐ Somewhat
☐ Moderately	☐ Moderately	☐ Moderately
☐ Quite a bit	☐ Quite a bit	☐ Quite a bit

Entertainment activities such as going to a movie or concert?

Bladder or urine	Bowel or rectum	Vagina or pelvis
☐ Not at all	☐ Not at all	☐ Not at all
☐ Somewhat	☐ Somewhat	☐ Somewhat
☐ Moderately	☐ Moderately	☐ Moderately
☐ Quite a bit	☐ Quite a bit	☐ Quite a bit

Ability to travel by car or bus for a distance greater than 30 minutes away from home?

Bladder or urine	Bowel or rectum	Vagina or pelvis
☐ Not at all	☐ Not at all	☐ Not at all
☐ Somewhat	☐ Somewhat	☐ Somewhat
☐ Moderately	☐ Moderately	☐ Moderately
☐ Quite a bit	☐ Quite a bit	☐ Quite a bit

Participating in social activities outside your home?

Bladder or urine	Bowel or rectum	Vagina or pelvis
☐ Not at all	☐ Not at all	☐ Not at all
☐ Somewhat	☐ Somewhat	☐ Somewhat
☐ Moderately	☐ Moderately	☐ Moderately
☐ Quite a bit	☐ Quite a bit	☐ Quite a bit

Associates in Urogynecology

Name:_____

Date:_____

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QUALITY OF LIFE ASSESSMENT

Emotional Health (nervousness, depression, etc.)?

Bladder or urine	Bowel or rectum	Vagina or pelvis
☐ Not at all	☐ Not at all	☐ Not at all
☐ Somewhat	☐ Somewhat	☐ Somewhat
☐ Moderately	☐ Moderately	☐ Moderately
☐ Quite a bit	☐ Quite a bit	☐ Quite a bit

Feelings of frustration?

Bladder or urine	Bowel or rectum	Vagina or pelvis
☐ Not at all	☐ Not at all	☐ Not at all
☐ Somewhat	☐ Somewhat	☐ Somewhat
☐ Moderately	☐ Moderately	☐ Moderately
☐ Quite a bit	☐ Quite a bit	☐ Quite a bit

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Patient's Health Insurance / Payment Agreement

I _____ agree that it is my responsibility to pay my applicable copayment, coinsurance, and/or deductible for every visit at Associates in Urogynecology at the time of service. I acknowledge that it is my responsibility to understand my health insurance coverage and that I will be liable for any amounts not covered by my health insurance for services rendered to me by AIU.

I understand that if on a payment plan, the credit card on file will be charged according to the plan.

Patient's Signature _____

Date_____

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Associates in Urogynecology

CONSENT TO TREATMENT:

Patient Name:_____ Date: _____

Date of Birth: _____

I, _____, hereby voluntarily consent to outpatient care at Associates in Urogynecology, encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work, administration of medications, or other as prescribed by the physician or their assistants, including nurse practitioners and physician's assistants. I authorize Associates in Urogynecology to release medical information to third party insurance carriers for the purpose of filing insurance claims related to my medical care. I authorize the release of medical information about treatment here to my doctor or anyone designated by me. I understand that this consent form will be valid and remain in effect as long as I receive medical care at Associates in Urogynecology.

Signature of Patient: _____

If a minor, Signature of Relative or Guardian: _____

Name of Relative or Guardian: _____

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Associates in Urogynecology

CONTACT BY EMAIL, PHONE, OR TEXT:

I authorize Associates in Urogynecology to contact me by (PLEASE CHECK ALL THAT APPLY):

☐ E-mail ☐ Phone Call ☐ Satisfaction Surveys

My preferred method is (circle one): Email Phone

I understand that Associates in Urogynecology cannot control the security of this information once e-mailed (if outside of our Patient Portal) and cannot take full responsibility of any breach in security during the electronic submission of my information.

Signature of Patient: _____

RELEASE OF INFORMATION & CONFIDENTIALITY

I, _____, hereby authorize the following individuals access to ALL of my health care information from Associates in Urogynecology. I understand that if no individuals are listed below, no one but myself will have access to my health information from AIU.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Patient: _____

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Associates in Urogynecology

Patient Acknowledgement of Provision of Notice of HIPAA Privacy Practices Policy

I, _____ acknowledge that Associates in Urogynecology has provided me with its Notice of Privacy Practices, and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices and agree to its terms.

Patient Name (Please Print): _____

Patient Signature: _____

Date: _____

-OR-

Personal Representative name (Please Print): _____

Signature of Personal Representative: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Office Use Only

AIU tried to obtain written Acknowledgement by the individual noted above of receipt of our HIPAA Notice of Privacy Practices, but it could not be obtained because:

___ An emergency prevented us from obtaining acknowledgement

___ A communication barrier prevented us from obtaining acknowledgement

___ The individual was unwilling to sign

___ Other:

Staff Member Signature: _____ Date: _____