UCPA UROLOGY OF CENTRAL PA, INC.

Patient Medical History - Adult Female

Patient Name:_____________________ **Height** _______ **Weight** _______

DOB: _____________________

Pharmacy name, address, phone number: ________________________________

Telephone number for patient: Home: ( ) Cell: ( )

Employment / Occupation: ________________________________

Emergency contact: Name: ________________ Phone: ( )

Who referred you for this consultation? (Self? Doctor? If so, from what clinic?) ________________

Describe the location/symptom/problem that is the reason for your visit: ________________

When did this problem start? ________________________________

Does anything make this problem better or worse? Please describe. ________________

Are there other associated problems? ☐ ☐No If yes, please describe: ________________

Please mark on the line the severity of your problem: **0 1 2 3 4 5 6 7 8 9 10** (None ... Moderate ... Severe)

ALLERGIES	
ALLERGY	**TYPE OF REACTION (Rash, Nausea, etc.)**

MEDICATIONS		
NAME	**DOSE**	**HOW OFTEN TAKEN**

PAST SURGICAL HISTORY

SURGERY		DATE/YEAR/MISCELLANEOUS
Appendix	☐	
Back	☐	
Bladder	☐	
Breast	☐	
Colon	☐	
Gallbladder	☐	
Heart Bypass	☐	
Heart Valve	☐	
Hernia	☐	
Hysterectomy	☐	
Kidney	☐	
Lung	☐	
Pelvic Laparoscopy	☐	
Thyroid	☐	
Total Joint Replacement	☐	
Right: ☐Hip ☐Knee		
Left: ☐Hip ☐Knee		
Urethra	☐	
Other/Explain:	☐	

HISTORY	YOU	FAMILY MEMBER	IF FAMILY MEMBER, RELATIONSHIP TO YOU
Anemia	☐	☐	
Arthritis	☐	☐	
Asthma	☐	☐	
Cancer	☐	☐	
Depression	☐	☐	
Diabetes	☐	☐	
GERD / Acid Reflux	☐	☐	
Gout (high uric acid)	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
Kidney Stones	☐	☐	
Liver Disease	☐	☐	
Mitral Valve Prolapse	☐	☐	
MRSA	☐	☐	
Osteoporosis	☐	☐	
Positive Mantoux/PPD	☐	☐	
Rheumatic Fever	☐	☐	
Thyroid Problems	☐	☐	
Toxic Exposure	☐	☐	
Tuberculosis	☐	☐	
Other/Explain:	☐	☐	

SOCIAL HISTORY

Bolded *questions in this section are Government-required due to the Health Care Reform Act.*

Marital Status? ☐Married ☐Single ☐Divorced ☐Widowed ☐Separated

Smoking Status? ☐Current Smoker ☐Former Smoker ☐Never Smoked

How many years if currently smoking? ___________________________ When did you quit? _________________

Do you ever drink alcohol? ☐Yes ☐No ☐Not Anymore ☐Never Drank

How many caffeinated drinks do you have each day? ☐0 ☐1 ☐2 ☐3 ☐4 or more

Have you had a blood transfusion? ☐Yes ☐No

What language do you speak? ________________________ **Race?** _________________________

Ethnicity? ☐Hispanic/Latino ☐Not Hispanic/Latino

Could you be pregnant? ☐Yes ☐No Do you have children? ☐Yes ☐No

Number of pregnancies __________ Number of Vaginal deliveries __________ Number of Caesarean __________

Have you ever had MRSA? ☐Yes ☐No

Positive Mantoux/PPD? ☐Yes ☐No

Are you on a special diet? ☐Yes ☐No If "Yes", please explain: ____

REVIEW OF SYSTEMS

Do you have any problems ***NOW*** *related to the following systems? Please circle Yes or No.*

Constitutional Symptoms		
Fever	Yes	No
Chills	Yes	No
Other ______________	Yes	No

Eyes		
Blurred vision	Yes	No
Double vision	Yes	No
Pain	Yes	No
Other ______________	Yes	No

Endocrine		
Excessive thirst	Yes	No
Too hot/cold	Yes	No
Tired/sluggish	Yes	No

Cardiovascular		
Chest pain	Yes	No
Varicose veins	Yes	No
High blood pressure	Yes	No
Other ______________	Yes	No

Integumentary		
Skin rash	Yes	No
Boils	Yes	No
Persistent rash	Yes	No
Other ______________	Yes	No

Respiratory		
Wheezing	Yes	No
Frequent cough	Yes	No
Shortness of breath	Yes	No
Other ______________	Yes	No

Gastrointestinal		
Abdominal pain	Yes	No
Nausea/vomiting	Yes	No
Indigestion/heartburn	Yes	No
Constipation	Yes	No
Irritable bowel syndrome	Yes	No
Other _____________	Yes	No

Musculoskeletal		
Joint pain	Yes	No
Neck pain	Yes	No
Back pain	Yes	No
Other _____________	Yes	No

Neurological		
Tremors	Yes	No
Dizzy spells	Yes	No
Numbness/tingling	Yes	No
Headache	Yes	No
Other _____________	Yes	No

Genitourinary		
Urine retention	Yes	No
Painful urination	Yes	No
Urinary frequency	Yes	No
Urinary tract infections	Yes	No
If Yes, # per year ___	Yes	No
Other _____________	Yes	No

Ear/Nose/Throat/Mouth		
Ear infection	Yes	No
Sore throat	Yes	No
Sinus problems	Yes	No
Other _____________	Yes	No

Allergic/Immunologic		
Hay fever	Yes	No
Drug allergies	Yes	No
Other ______________	Yes	No

Hematologic/Lymphatic		
Swollen glands	Yes	No
Blood clotting problem	Yes	No
Pulmonary embolism	Yes	No
Other _____________	Yes	No

Sexual History		
Sexually active?	Yes	No
Pain with intercourse?	Yes	No
Leaking urine with intercourse?	Yes	No

Psychologic		
Are you generally satisfied with your life?	Yes	No
Do you feel severely depressed?	Yes	No
Have you ever considered suicide?	Yes	No
Other _____________	Yes	No

Gynecologic		
Heavy periods	Yes	No
Irregular periods	Yes	No
Menopause	Yes	No
If Yes, when? __________________		
Hormone therapy	Yes	No
If Yes, type: ____________________		

Urogenital Distress Inventory-6
Incontinence Impact Questionnaire-7 Form

UDI-6 Urogenital Distress Inventory

Do you experience the following? If so, how much are you bothered by:	**NOT AT ALL**	**SLIGHTLY**	**MODERATELY**	**GREATLY**
Frequent urination?	0	1	2	3
Urine leakage related to the feeling of urgency (sudden desire to urinate)?	0	1	2	3
Urine leakage related to physical activity, coughing or sneezing?	0	1	2	3
Small amounts of urine leakage (drops)?	0	1	2	3
Difficulty emptying your bladder?	0	1	2	3
Pain or discomfort in the lower abdominal or genital area?	0	1	2	3

Symptom Score: ____________

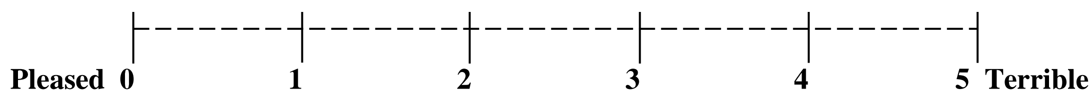
IIQ-7 Incontinence Impact Questionnaire

Has the leakage of urine and/or prolapse affected:	**NOT AT ALL**	**SLIGHTLY**	**MODERATELY**	**GREATLY**
Your ability to do household chores (cooking, housecleaning)?	0	1	2	3
Your physical recreation such as walking, or other exercise?	0	1	2	3
Your ability to attend entertainment activities (movies, concerts)?	0	1	2	3
Your ability to travel by car more than 30 minutes from home?	0	1	2	3
Your participation in social activities outside your home?	0	1	2	3
Your emotional health (nervousness, depression, etc.)?	0	1	2	3
Made you feel frustrated?	0	1	2	3

Bother Score: ____________

Quality of life due to urinary problems:

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that? Circle the number that best reflects your feelings about your urinary problem.



Pleased 0 1 2 3 4 5 Terrible

QOL Score: ____________

3 Day Voiding Diary

NAME: ____________________
DATE

Time of Day	Leak? Y or N	Change Pad? Y or N	Urgency ? Rate 1-5* (1=Best 5=Worst)
12:35	Y	N	5

#of voids ________
# of leaks ______
# of pads _________
# of night episodes _______
Average Urgency Rate ________

DATE

Time of Day	Leak? Y or N	Change Pad? Y or N	Urgency ? Rate 1-5

#of voids ________
# of leaks ______
# of pads _________
# of night episodes _______
Average Urgency Rate ________

DATE

Time of Day	Leak? Y or N	Change Pad? Y or N	Urgency ? Rate 1-5

#of voids ________
# of leaks ______
# of pads _________
# of night episodes _______
Average Urgency Rate ________

FINANCIAL POLICY

Urology of Central Pennsylvania is committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

****PAYMENT OF COPAYS, DEDUCTIBLES AND NON-COVERED AMOUNTS IS DUE AT THE TIME OF SERVICE. We accept Cash, Checks, Visa, Mastercard, Discover, American Express and CareCredit.****

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. We will bill your insurance carrier according to our agreement with them based on the insurance information you have provided to us. We file insurance claims as a courtesy to you. We will not become involved in disputes between you and your insurance company regarding deductibles, copays, referrals, covered & non-covered services, secondary insurance, etc. other than to supply factual information as necessary.

Urology of Central Pennsylvania's CT scan, ultrasound, radiation therapy, clinical laboratory and pathology services are owned and operated by UCPA for the benefit of our patients. If your UCPA physician concludes that CT scan, clinical laboratory, pathology, radiation therapy or ultrasound services are medically necessary because of your condition, you may have your CT scan, radiation therapy, ultrasound, clinical laboratory or pathology performed at UCPA, or at any other facility, if you choose to do so.

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THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY.
PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS,
OUR BILLING DEPARTMENT WILL BE HAPPY TO HELP YOU.

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YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT

I understand that I am financially responsible for all co-payments, deductibles, co-insurance and all amounts my insurance does not cover. In the event I fail or refuse to submit timely payment for all co-payments, deductibles, co-insurance and amounts any commercial or government third party payer does not cover, I agree to pay 30% of said outstanding amount as a collection fee. I intend to be legally bound hereby.

I request that payment of authorized medical benefits, including Medicare benefits be made either to me or on my behalf to Urology of Central Pennsylvania for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services and its agents, my insurance company or its intermediaries, this physician's office or other physician's offices any information needed to determine these benefits or benefits payable for related services or as may be needed for my medical care. I permit a copy of this authorization to be used in place of the original.

Signature____ Date______________________

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Urology of Central Pennsylvania for any services furnished to me by that physician or supplier. I authorize any holder of Medicare information about me to release to ______________________ any information needed to determine these benefits or the benefits payable for related services.

Signature____ Date_______________________

Revised January 2011