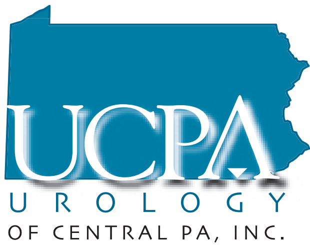

PATIENT MEDICAL HISTORY ADULT FEMALE

PATIENT INFORMATION

Patient Name: ______________________ Date of Birth: __________

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

Signature: ______________________ Date: __________

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:	☐	

MEDICAL HISTORY

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

Signature: ______________________________ Date: ______________

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? ______________

Alcohol Status ☐ Yes ☐ No ☐ Not Anymore ☐ Never Drank

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

Have you ever had a blood transfusion? ☐ Yes ☐ No

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

Number of pregnancies ________ Number of vaginal deliveries ________ Number of Caesarean ________

REVIEW OF SYSTEMS

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

Constitutional Symptoms

Fever ☐ Yes ☐ No

Chills ☐ Yes ☐ No

Other ____________ ☐ Yes ☐ No

Respiratory

Wheezing ☐ Yes ☐ No

Frequent cough ☐ Yes ☐ No

Shortness of breath ☐ 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

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

Night time urination ☐ Yes ☐ No

If Yes, # ____________

Hematologic / Lymphatic

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

Menopause ☐ Yes ☐ No

If Yes, when ____________

Hormone therapy ☐ Yes ☐ No

If Yes, type ____________

Signature: ______________________________________ Date: ____________

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: ____________________

Signature: ______________________________ Date: ____________

3 DAY VOIDING DIARY

UCPA
UROLOGY
OF CENTRAL PA, INC.

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

POS Reorder # 1608707

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 ARE DUE AT THE TIME OF SERVICE.
We accept Cash, Checks, Visa, Mastercard, Discover, American Express and Care Credit****

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.

**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.**

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, coinsurance 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 also understand that if I fail to keep my scheduled appointments, I may be charged an unkept office visit fee of $30.00.

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 of 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: ______________