



ILLINOIS UROGYNECOLOGY, LTD.

REGISTRATION FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES

Name: Last	First	Maiden Name	Date of Birth	Age
Street Address		Single Divorced	Married 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
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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
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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:

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 _____

Date of visit: ____/____/____

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<i>Surgery/Procedure</i>	<i>Date/Year</i>	<i>Hospital</i>	<i>Surgeon</i>
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