Florida Urogynecology

Patient Name (Please Print): ____________________

Street Address: ____________________ SSN: ____________________

City/State: ____________________ Zip Code: __________ DOB: ______________

Marital Status: ________ Home Phone: ____________________ Work Phone: ______________

Cell Phone: ____________________ Employer: ____________________

Race: ______________ Language: ____________________

Ethnicity (please circle one): Hispanic or Latino / Not Hispanic or Latino / Do Not Wish to Disclose

Email address: ____________________

Spouse or Parent Information

Name: ____________________ SSN: ____________________

DOB: ______________ Employer: ____________________

Home Phone: ____________________ Business Phone: ______________

Relationship to Patient: ____________________

Note: All Payments are due at the time of service. Copies of insurance cards and appropriate referral information must be received prior to physician contact.

Insurance Information

Primary Insurance: ____________________ Group #: ______________

Insurance ID Number: ____________________ Policy Holder: ______________

Effective Date of Coverage: ____________________ **PRESENT CARD TO STAFF**

Secondary Insurance: ____________________ Group #: ______________

Insurance ID Number: ____________________ Policy Holder: ______________

Effective Date of Coverage: ____________________ **PRESENT CARD TO STAFF**

Emergency Contact: ____________________ Phone: ______________

I hereby certify that the above information given by me in applying for payment of medical services is accurate. In addition, I request that payment of authorized Medicare/Other insurance company benefits be made on my behalf to Florida Urogynecology for any services furnished to me by that party who accepts assignments. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other insurance company claim. I permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits to Florida Urogynecology I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.

New Patient Information

Patient Name: ______________________________________ AGE __________

Height: _____ Weight: _____ Primary Care Doctor & Telephone #:______________________

Referring Physician Name & Telephone #:____

Pharmacy Name & Telephone #: ____

How did you hear about us? ____

Reason for Visit:

____

____

Is this visit due to a work related injury or an automobile accident: ________

Current Medical Problems: (Please circle all)

Arthritis	Y N		High Blood Pressure	Y N
Asthma	Y N		High Cholesterol	Y N
Blood Clots	Y N		Irritable Bowel Syndrome	Y N
Bronchitis	Y N		Kidney Disease or Stones	Y N
Cancer	Y N		Mitral Valve Prolapse	Y
COPD/Emphysema	Y N		Reflux	Y N
Diabetes	Y N		HyperThyroidism	Y N
Glaucoma	Y N	(open / closed)	HypoThyroidism	Y N
Heart Disease	Y N		Ulcers	Y N

Other : ____

OB/GYN History: **Regular gynecologist:** ____________________

Number of Pregnancies: _____ Number of Live Births: _____ Number of C-Sections: _______

Last Mammogram: (Normal / Abnormal) Last Pap Smear: __________ (Normal / Abnormal)

Last Menstrual Cycle: _________ (Regular / Irregular) Menstrual Problems: Y N

Age of 1st Period: ___________ Sexually Active: Y N

Menopause Since: __________________ Last Colonoscopy: ____________ (Normal/Abnormal)

Surgical History:

Hysterectomy: Y N Date: __________ if yes, please circle whether it was **Abdominal**, **Laparoscopic**, or **Vaginal**. **Ovaries Removed**: Yes/No (RT / LT / Both)

Bladder Repair: Y N Date: __________ Type: ______________________

Surgeon: ____________________ Where: ____________________

Other Surgeries Date: __________ Type: ______________________

Date: __________ Type: ______________________

Date: __________ Type: ______________________

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Medication Drug Allergies & Reaction: (Please list)

____

____

____

Current Medications – including Over the Counter Medications and Vitamins:

Name:	Dose/How Often:	Why are you taking this medication?
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

Vaccination Dates:

Flu Vaccine: ___________ Pneumonia Vaccine: ____________ Zoster Vaccine: ___________

Covid-19 Vaccine: ______________, _____________ Please circle one: (Pfizer, Moderna, J&J)

Family History: (Please circle all and write relation) (Example: Grandmother/Aunt/Sister)

Breast Cancer	Y N	____________	Hypertension	Y N	____________
Colon Cancer	Y N	____________	Ovarian Cancer	Y N	____________
Diabetes	Y N	____________	High Cholesterol	Y N	____________
Heart Disease	Y N	____________	Stroke	Y N	____________

Others not listed above: ____

____

Social History: (Please check all that apply)

Marital Status: □ Single □ Married □ Divorced □ Widowed

Alcohol: □ Never □ Rarely □ Moderate □ Daily

Tobacco Use: □ Never □ Currently Smoke _______ Pack/Day for ______Years

□ Stopped in ________________ If Current Smoker have you tried to quit? _______

Caffeine Use: □ None □ 1-2 Cups/Day □ 4-6 Cups/Day □ More Than 6 Cups/Day

Drug Use: □ Never □ Yes, Type: ______________________________

Living Will: Y N

Referring Physician: ______________________________

Review of Systems: (*Please circle Yes or No to every question*)

Constitutional:

Recent weight change	Y N
Fever	Y N
Fatigue	Y N

Eyes/Ears/Nose/Throat:

Hearing loss/ringing	Y N
Chronic sinus problems	Y N
Sore throat	Y N

Eyes: ____________________

Cardiovascular:

Chest pain	Y N
Ankle swelling	Y N
Irregular heart beat	Y N
Waking up short of breath	Y N

Respiratory:

Chronic cough	Y N
Short of breath with activity	Y N
Sleeping on more than 1 pillow	Y N

Gastro-intestinal:

Nausea/vomiting	Y N
Frequent diarrhea	Y N
Bloody/painful bowel Movements	Y N

Genitourinary:

Vaginal discharge	Y N
Visible Blood in urine	Y N
Recurrent Bladder infections	Y N
Kidney Stones	Y N
Kidney Failure	Y N

Fall Risk:

Two or more falls within 12 months	Y N

Musculoskeletal:

Joint pain	Y N
Muscle pain	Y N
Back pain	Y N
Stiffness	Y N

Integumentary:

Rash/itching	Y N
Breast pain/lump	Y N
Varicose veins	Y N

Neurological:

Headaches	Y N
Dizziness	Y N
Convulsions	Y N
Paralysis/Numbness	Y N

If Yes where: ____________________

Psychiatric:

Memory loss	Y N
Depression	Y N
If Yes is it being managed?	Y N

Endocrine:

Heat Intolerance	Y N
Cold Intolerance	Y N
Excessive Thirst	Y N
Glandular/Hormone Problem	Y N

Hematological:

Anemia	Y N
Past transfusion	Y N
Free Bleeder	Y N

Other:

____

____

____

FLORIDA UROGYNECOLOGY
AND
RECONSTRUCTIVE PELVIC SURGERY,PA

PATIENT INFORMATION RELEASE AND AUTHORIZATION FOR USE OF ANSWERING MACHINES and EMAIL

I, ___________________________ (name of patient), authorize "Florida Urogynecology & Reconstructive Pelvic Surgery, P.A." to provide detailed information to me via my home and/or work answering machine, cell phone voice mail, and/or email concerning appointment, referral and test information. I understand that information left on an answering machine could be overheard by others. Please leave messages for me on the telephone number designated below. I understand that I may revoke this authorization at any time.

I release Florida Urogynecology & Reconstructive Pelvic Surgery, P.A. from any and all legal liability that may arise from leaving this information on my answering machine.

___________________________ ___________________________
Patient Signature **Designated phone number**

____
Date

I give my permission for Florida Urogynecology & Reconstructive Pelvic Surgery to release information regarding my medical condition to the following:

Name	**Relationship**
___________________________	___________________________
___________________________	___________________________
___________________________	___________________________
___________________________	___________________________

___________________________ ___________________________
Patient's Signature **Date**

Florida Urogynecology

Patient Name: ______________________________

Privacy Notice Acknowledgement

I acknowledge that I have had the opportunity to receive a copy of Florida Urogynecology Privacy. I understand that I am responsible to read this Notice and notify Florida Urogynecology in writing, of any request for restrictions on the use or disclosure of my individually identifiable health information. Florida Urogynecology has the right to revise this Notice at any time and will post a copy of the current notice in the office in a visible location at all times. Florida Urogynecology will provide me with a copy of its most recent Notice upon my request.

Financial Responsibility

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Florida Urogynecology I am responsible for any applicable deductible or co-payments prior to the provision of services. I understand that by law, deductible, co-payment, and co-insurance cannot be waived. For surgery, Florida Urogynecology will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment and/ or procedure this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. I further understand that such payment is not contingent on the results of any treatment. Florida Urogynecology does not refund any payment for services rendered.

Florida Urogynecology may file a claim for payment with my insurance company as required by contractual agreement. I understand that if my insurance company sends me a check for payment of the services provided by Florida Urogynecology the check belongs to Florida Urogynecology. and I must immediately deliver the check to Florida Urogynecology for payment on my account. If the insurance company fails to pay Florida Urogynecology in a timely manner I understand that I will be responsible for prompt payment of all amounts owed to Florida Urogynecology. I understand that I am financially responsible for all amounts not covered by my insurance company. Should the account be referred to a collection agency or attorney for collections, the undersigned shall pay all cost of collection, including reasonable attorney's fee.

Additional Information

Florida Urogynecology accepts payment in cash, check and credit cards. There is a $25.00 fee for returned checks. This fee is in addition to any fees that may be assessed by my bank for returned checks. In the event that I pay by credit card, I understand that the credit card must not have expired and not reached its available credit limit.

In the event that I receive a payment from my insurance carrier, I agree to endorse any payment due for services rendered to Florida Urogynecology.

Consent for Treatment

I give my consent to Florida Urogynecology to provide medical care, diagnostic testing and treatment deemed medically necessary and proper in diagnosing or treating my medical condition. In the event that my condition requires a procedure or surgery, I understand that I will execute a specific informed consent for such procedure or surgery.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

______________________________ ______________________

Signature Date

Florida Urogynecology & Reconstructive Pelvic Surgery, PA

Pelvic Floor Distress Inventory

Instructions:
Please answer these questions by putting an X in the appropriate box.
If you are unsure about how to answer a question, give the best answer you can.
While answering these questions, Please consider your symptoms over the last 3months.
Thank you for your help.

Name: ______________________________ Date: ________________

1. Do you usually experience *pressure* in the lower abdomen? ☐No ☐Yes

☐1	☐2	☐3	☐4
Not at All	Somewhat	Moderately	Quite a Bit

2. Do you usually experience *heaviness or dullness* in the pelvic area? ☐No ☐Yes, how much does this bother you?

☐1	☐2	☐3	☐4
Not at All	Somewhat	Moderately	Quite a Bit

3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area? ☐No ☐Yes - if yes, how much does this bother you?

☐1	☐2	☐3	☐4
Not at All	Somewhat	Moderately	Quite a Bit

4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement? ☐No ☐Yes - if yes, how much does this bother you?

☐1	☐2	☐3	☐4
Not at All	Somewhat	Moderately	Quite a Bit

5. Do you usually experience a feeling of incomplete bladder emptying? ☐No ☐Yes - if yes, how much does this bother you?

☐1	☐2	☐3	☐4
Not at All	Somewhat	Moderately	Quite a Bit

6. Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination? ☐No ☐Yes - if yes, how much does this bother you?

☐1	☐2	☐3	☐4
Not at All	Somewhat	Moderately	Quite a Bit

7. Do you feel you need to strain too hard to have a bowel movement? ☐No ☐Yes
If other than never, how much does this bother you?

☐1	☐2	☐3	☐4
Not at All	Somewhat	Moderately	Quite a Bit

8. Do you feel you have not completely emptied your bowels at the end-of a bowel movement?
☐No ☐Yes - if other than never, how much does this bother you?

☐1	☐2	☐3	☐4
Not at All	Somewhat	Moderately	Quite a Bit

9. Do you usually lose stool beyond your control if your stool is well formed? ☐No ☐Yes
If yes, how much does this bother you?

☐1	☐2	☐3	☐4
Not at All	Somewhat	Moderately	Quite a Bit

10. Do you usually lose stool beyond your control if your stool is loose or liquid? ☐No ☐Yes - If yes, how much does this bother you?

☐1 Not at All ☐2 Somewhat ☐3 Moderately ☐4 Quite a Bit

11. Do you usually lose gas from the rectum beyond your control? ☐No ☐Yes - if yes, how much does this bother you?

☐1 Not at All ☐2 Somewhat ☐3 Moderately ☐4 Quite a Bit

12. Do you usually have pain when you pass your stool? ☐No ☐Yes - if yes, bow much does this bother you?

☐1 Not at All ☐2 Somewhat ☐3 Moderately ☐4 Quite a Bit

13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement? ☐No ☐Yes

☐1 Not at All ☐2 Somewhat ☐3 Moderately ☐4 Quite a Bit

14. Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement? ☐No ☐Yes - if yes, how much does this bother you?

☐1 Not at All ☐2 Somewhat ☐3 Moderately ☐4 Quite a Bit

15. Do you usually experience frequent urination? ☐No ☐Yes - if yes, how much does this bother you?

☐1 Not at All ☐2 Somewhat ☐3 Moderately ☐4 Quite a Bit

*16. Do you usually experience urine leakage associate with a feeling of urgency that is a strong sensation of needing to go to the bathroom? ☐No ☐Yes - if yes, bow much does this bother you?

☐1 Not at All ☐2 Somewhat ☐3 Moderately ☐4 Quite a Bit

17. Do you usually experience urine leakage related to coughing, sneezing, or laughing? ☐No ☐Yes - if yes, how much does this bother you?

☐1 Not at All ☐2 Somewhat ☐3 Moderately ☐4 Quite a Bit

18. Do you usually experience small amounts of urine leakage (drops)? ☐No ☐Yes - if yes, how much does this bother you?

☐1 Not at All ☐2 Somewhat ☐3 Moderately ☐4 Quite a Bit

19. Do you usually experience difficulty emptying your bladder? ☐No ☐Yes - if yes, how much does this bother you?

☐1 Not at All ☐2 Somewhat ☐3 Moderately ☐4 Quite a Bit

20. Do you usually experience *pain or discomfort* in the lower abdomen or genital region? ☐No ☐Yes - if yes, how much does this bother you?

☐1 Not at All ☐2 Somewhat ☐3 Moderately ☐4 Quite a Bit

Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire
Instructions: The following are a list of questions about you and your partner's sex life. All information is strictly confidential. Your confidential answers will be used only to help the doctor to understand what is important to the patient about their sex lives. Please check the box that best answers the question for you. While answering the questions, consider your sexuality over the past six months. Thank you for your help.

☐ **Not Applicable**

1. How frequently do you feel sexual desire? This feeling may include wanting to have sex, feeling frustrated due to lack of sex, etc.?

☐Always ☐Usually ☐Sometimes ☐Seldom ☐Never

2. Do you climax (have an orgasm) when having sexual intercourse with your partner?

☐Always ☐Usually ☐Sometimes ☐Seldom ☐Never

3. Do you feel sexually excited (turned on) when having sexual activity with your partner?

☐Always ☐Usually ☐Sometimes ☐Seldom ☐Never

4. How satisfied are you with the variety of sexual activities in your current sex life?

☐Always ☐Usually ☐Sometimes ☐Seldom ☐Never

5. Do you feel pain during sexual Intercourse?

☐Always ☐Usually ☐Sometimes ☐Seldom ☐Never

6. Are you incontinent of urine (leak urine) with sexual activity?

☐Always ☐Usually ☐Sometimes ☐Seldom ☐Never

7. Does fear of incontinence (either stool or urine) restrict your sexual activity?

☐Always ☐Usually ☐Sometimes ☐Seldom ☐Never

8. Do you avoid sexual intercourse because of bulging in the vagina (the bladder, rectum or vagina falling out?)

☐Always ☐Usually ☐Sometimes ☐Seldom ☐Never

9. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?

☐Always ☐Usually ☐Sometimes ☐Seldom ☐Never

10. Does your partner have a problem with erections that affects your sexual activity?

☐Always ☐Usually ☐Sometimes ☐Seldom ☐Never

11. Does your partner have a problem with premature ejaculation that affects your sexual activity?

☐Always ☐Usually ☐Sometimes ☐Seldom ☐Never

12. Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?

☐Much less intense ☐Less intense ☐Same intensity ☐More intensity

☐Much more intense

Consent for Pelvic Examination

According to The American College of Obstetricians and Gynecologists, the pelvic examination is part of the evaluation of women presenting with many common conditions, including pelvic pain, abnormal bleeding, vaginal discharge, and sexual problems. Pelvic exams—both in the office and while under anesthesia— are also an important part of evaluation for gynecologic procedures to ensure safe completion of the planned procedure. Often, a pelvic examination is performed for women without symptoms while looking for gynecologic cancer, infection, and pelvic inflammatory disease.

A pelvic examination is an assessment of the external genitalia; internal speculum examination of the vagina and cervix; bimanual palpation of the adnexa, uterus, and bladder; and sometimes rectovaginal examination. This may also include possible urethral catheterization.

Reasons for a pelvic exam can include (but are not limited to) health screening, abnormal bleeding, pelvic pain, sexual problems, vaginal bulge, urinary issues, or inability to insert a tampon. Other indications include patients undergoing a pelvic procedure (e.g., endometrial biopsy or intrauterine device placement). Also, pelvic examination is indicated in women with current or a history of abnormal pap results, gynecologic cancers, or toxic exposures.

The potential benefits of a pelvic examination include the detection of vulvar, vaginal, cervical, uterine and ovarian cancers and precancers, yeast and bacterial vaginosis, trichomoniasis, and genital herpes, early detection of treatable gynecologic conditions before symptoms begin occurring (e.g. vulvar or vaginal cancer), as well as incidental findings such as dermatologic changes and foreign bodies. Additionally, screening pelvic examinations in the context of a well woman visit may allow gynecologists to explain a patient's anatomy, reassure her of normalcy, and answer your specific questions.

The potential risks of a pelvic exam may include (but are not limited to) fear, anxiety, embarrassment (reports ranged from 10% to 80% of women) or pain and discomfort (from 11% to 60%).

There are few alternatives to pelvic examination, the alternatives are not as effective for providing diagnostic or evaluative information and carry their own set of potential risks. If you have concerns, you should discuss with your healthcare provider.

I ________________________________ understand that this Patient Consent Form is required by law. I understand that I need to sign this form to show that I am making an informed decision to have pelvic examinations and I have read and understand the above.

The provider or their delegate has explained to me the nature, purpose, and possible consequences of each procedure as well as risks involved, possible complications, and possible alternative methods of treatment. I also know that the information given to me does not list every possible risk and that other, less likely problems could occur. I was not given any guarantee from anyone about the final results of this procedure.

________________________________ ____/____/________

Signature Date

Below To be Signed if a Medical Professional is in Training:

I understand that my provider is involved in educating tomorrow's medical professionals and that familiarizing students with the female anatomy and instilling a physician workforce with confidence in pelvic examination skills is essential. I consent to pelvic examination by the medical professional student under the supervision of my medical provider.

________________________________ ____/____/________

Signature Date