Name_____ DOB_____ Date_____

MEDICAL HISTORY

MEDICAL HISTORY: Have you **ever** had, or do you **now** have any of the following? (Check all that apply)

- ☐ **None / Healthy**
- ☐ Anemia
- ☐ Angina/heart attack
- ☐ Arthritis/joint disease
- ☐ Asthma (bronchial)
- ☐ Breast cancer
- ☐ Congestive Heart Failure
- ☐ Cardiac Stent
- ☐ COPD/Emphysema
- ☐ Coronary Artery Disease
- ☐ Chronic Kidney Disease
- ☐ DVT/Blood Clot
- ☐ Dementia/Alzheimer's
- ☐ Depression
- ☐ Diabetes: Type ____
- ☐ Drug Abuse
- ☐ Heart Condition
- ☐ Heart Murmur
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ High blood pressure
- ☐ Inflammatory Bowel (IBS)
- ☐ Kidney Stones
- ☐ Myasthenia Gravis
- ☐ Multiple Sclerosis
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Parkinson Disease
- ☐ Peptic Ulcer Disease/GERD
- ☐ Peripheral Neuropathy
- ☐ Scoliosis
- ☐ Seizure Disorder
- ☐ Sleep Apnea/CPAP
- ☐ Spinal Stenosis
- ☐ Stroke
- ☐ Systemic Lupus
- ☐ Thyroid Disease

MEDICATIONS:

List **(or attach a copy)** including: ALL **of your medications that you are currently taking (include DOSAGE and HOW OFTEN you take them). Also include any hormones, herbal medications, vitamins, and over the counter medicines you routinely take:**

_____

_____

_____

Over-the-counter: (aspirin, Tylenol, ibuprofen, Aleve, vitamins and herbals)

_____

Do you take blood thinners *(check box) ?:* ☐Coumadin ☐Plavix ☐Eliquis ☐Aspirin

Do you have a history of Chronic Back Problems, pain, injections or surgery (*circle*)? Yes No

If yes, describe: _____

MEDICATION ALLERGIES (if yes, please explain what reaction, for example, hives, wheezing, upset stomach, swelling, etc.)

- ☐ No Known Allergies
- ☐ Aspirin/Type of allergic reaction_____
- ☐ Sulfa/Type of allergic reaction_____
- ☐ Codeine/Type of allergic reaction_____
- ☐ Penicillin /Type of allergic reaction_____
- ☐ Latex/Type of allergic reaction_____
- ☐ Metal (nickel, copper)/ /Type of allergic reaction_____
- ☐ Other /type of allergic reaction_____
- ☐ Other /type of allergic reaction_____

SURGICAL HISTORY

Please check the box for operations that you have had. List the year and surgeon/location where you had the surgery.

○ Abdominal Hysterectomy Date: Surgeon/Location:	○ Vaginal Hysterectomy Date: Surgeon/Location:	○ Ovaries Removed Date: Surgeon/Location:
○ Bladder Surgery for Leakage Date: Surgeon/Location:	○ Prolapsed Surgery/A&P repair Mesh Used (circle)? Yes No Date: Surgeon/Location:	○ Hernia Surgery Mesh Used (circle)? Yes No Date: Surgeon/Location:
○ Heart Surgery Date: Surgeon/Location:	○ Back Surgery Date: Surgeon/Location:	○ Bone/Joint Surgery Inserted Metal (circle)? Yes No Date: Surgeon/Location:
○ Gall Bladder Surgery Date: Surgeon/Location:	○ Appendectomy Date: Surgeon/Location:	○ Hemorrhoidectomy Date: Surgeon/Location:

List any other surgeries that you have had that are not described above:

_____

_____

Have you ever required a blood transfusion (*circle*)? Yes No Do you accept blood transfusion if needed: Yes No _____

History of joint replacement <3 years (*circle*)? Yes No Do you require antibiotics before dental or surgical procedures ? Yes No

Physician Initial: _____

FAMILY HISTORY ☐ None

☐ Father: Living:- Age: Deceased: Age at death: Cause

☐ Mother: Living:- Age: Deceased: Age at death: Cause

☐ Siblings: Numbe Living: Number Deceased: Cause

☐ Cancer:

☐ Kidney Disease ☐ Arthritis ☐ Gout

☐ Heart Disease ☐ Liver Disease ☐ Blood clots

☐ Prolapse ☐ Incontinence

☐ Bladder cancer ☐ Kidney cancer

OBSTETRICAL AND GYNECOLOGICAL HISTORY

# of Pregnancies: ___ Vaginal: ___ Cesarean section: ____

Largest Baby: __ Forceps or Vacuum used? Yes No Not Sure

Were there any tears into your rectum? Yes No Not Sure

Are you planning to have more children? Yes No Not Sure

Last menstrual period: _____Last pelvic exam: _____

Have you ever taken hormone therapy ? Yes No

Type:_____

Last PAP smear: _____ Normal ? Yes No

Last mammogram: _____ Normal ? Yes No

Date of your last colon cancer screening: _____

Type: hem occult, sigmoidoscopy, colonoscopy, or barium enema (*circle*)? Was it Normal (*circle*)? Yes No Not Sure

SOCIAL HISTORY

Tobacco Use? ☐ Never ☐ Former ☐ Current

Do you want to quit? ☐ Yes ☐ No

Tobacco Type? Usage per Day? # packs /day? # years?

Ever Tried to Quit? Method to quit? When did you stop?

Alcohol? ☐ None ☐ Socially ☐ Rarely ☐ Occasionally ☐ Yearly ☐ Weekly ☐ Daily

Caffeine Intake? ☐ Yes ☐ No Per Day?

# of servings of Coffee per day_____

# of servings of Tea per day_____

# of servings of Soda per day_____

Recreational drugs? (marihuana, cocaine, other) ☐ Yes ☐ No

If yes, what and when:

Do you exercise regularly (*circle*)? Yes No

What is the most vigorous activity you do?

_____

Do you sleep regularly (*circle*)? Yes No

Are you currently employed (*circle*)? Yes No If yes, what is your job/activity? _____

Does your job/activity require heavy lifting (*circle*)? Yes No

How far do you live from STAR Clinic (minutes' drive)? ____

Who do you live with at home?: _____

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION I HAVE PROVIDED IS ACCURATE.

_____

Patient / Legal Guardian Signature Date

Physician Initial: _____

STAR Clinic

Name: _____

DOB:

Age:_____

Today's date:_____

NEW UROGYNECOLOGY CONSULT QUESTIONNAIRE- Dr. Diaz V

PHYSICIAN: _____Provider_____
Where you referred? ☐ **No** ☐ By Whom?: _____
Preferred Pharmacy:

In your own words, please write the nature of the medical problem for which you are being seen today.

_____

_____

How long have you had these symptoms? __Weeks __months __years
What are your goals for this consultation? _____
What do you hope to be able to do after treatment that you are having difficulty doing now? _____

SYMPTOMS (in the last month):

1. How often do you urinate during the day? Every _____ hours
2. How often do you leak urine (*check **one** box only*)?

☐ Never ☐ 1 time/Week ☐ 2-3 times/Week ☐ 1 time/Day ☐ Several times/Day ☐ All the Time

3. How much urine do you usually leak, whether you are wearing a pad or not (*check one box only*)?

☐ None ☐ Small Amount ☐ Moderate Amount ☐ Large Amount

4. Overall how does leaking urine interfere with your everyday life? *Circle a number a number between 0 (not at all) and 10 (a great deal).*

0 1 2 3 4 5 6 7 8 9 10

5. When do you leak urine (*check ALL that applies*)?

Never ☐
Before I get to the toilet ☐
When I hear, see, feel running water ☐
When it is cold outside ☐
When I put my key in the door ☐
When I have sex ☐
When I lift heavy objects ☐
When I cough/sneeze ☐
When I am physically active/exercise ☐
When I stand up ☐
After I am done urinating/stand up from the toilet ☐
When I am asleep ☐
For no obvious reason ☐
I leak all the time ☐

6. Circle T for True or F for False, whichever applies to you:

T F I have to wear pads because of losing urine. **How many** pads do you use per day?:_____
Circle which: Panty-liners, sanitary pads, Incontinence pads, Disposable briefs/diapers
T F The need to urinate wakes me up **at least 2** times per night.
If so, how many times do you usually get up out of bed? _____ Do you wake up wet? **Yes** ☐ **No** ☐
T F I know where every restroom is located in the places I go.
T F I had 2 or more bladder infections in the last year. **If so, how many**? _____
T F I have trouble starting a urinary stream.
T F My urine stream is no more than a dribble.
T F It takes me a long time to empty my bladder.
T F I strain to urinate.

Answer the following questions by considering your symptoms in the last 3 MONTHS. If you answer "Yes", then rate how much it BOTHERS you (*check one box only*). 0- Not at all 1- Somewhat 2- Moderately 3- Quite a bit

1. Do you usually experience *pressure* in the lower abdomen? **Yes** ☐ **No** ☐ **0 1 2 3**
2. Do you usually experience *heaviness or dullness* in the pelvic area? **Yes** ☐ **No** ☐ **0 1 2 3**
3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area? **Yes** ☐ **No** ☐ **0 1 2 3**
4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement? **Yes** ☐ **No** ☐ **0 1 2 3**

Physician Initial: _____

5. Do you usually experience a feeling of incomplete bladder emptying? **Yes ☐ No ☐** **0 1 2 3**

6. Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination? **Yes ☐ No ☐ 0 1 2 3**

7. Do you feel you need to strain too hard to have a bowel movement? **Yes ☐ No ☐** **0 1 2 3**

8. Do you feel you have not completely emptied your bowels at the end of a bowel movement? **Yes ☐ No ☐** **0 1 2 3**

9. Do you usually lose stool beyond your control if your stool is well formed? **Yes ☐ No ☐** **0 1 2 3**

10. Do you usually lose stool beyond your control if your stool is loose or liquid? **Yes ☐ No ☐** **0 1 2 3**

11. Do you usually lose gas from the rectum beyond your control? **Yes ☐ No ☐** **0 1 2 3**

12. Do you usually have pain when you pass your stool? **Yes ☐ No ☐** **0 1 2 3**

13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement? **Yes ☐ No ☐ 0 1 2 3**

14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement? **Yes ☐ No ☐ 0 1 2 3**

15. Do you usually experience frequent urination? **Yes ☐ No ☐** **0 1 2 3**

16. Do you usually experience urine leakage associated with a feeling of urgency that is a strong sensation of needing to go to the bathroom? **Yes ☐ No ☐** **0 1 2 3**

17. Do you usually experience urine leakage related to coughing, sneezing, or laughing? **Yes ☐ No ☐** **0 1 2 3**

18. Do you usually experience small amounts of urine leakage (that is, drops)? **Yes ☐ No ☐** **0 1 2 3**

19. Do you usually experience difficulty emptying your bladder? **Yes ☐ No ☐** **0 1 2 3**

20. Do you usually experience *pain* or *discomfort* in the lower abdomen or genital region? **Yes ☐ No ☐** **0 1 2 3**

For the following questions, check the response that best describes how many your activities, relationships, or feelings have been affected by your bladder, bowel, or vaginal symptoms or conditions over the last 3 months. Please mark an answer in ALL 3 columns.

How do symptoms or conditions related to the following ⇒ usually affect your ⇓	**Bladder or urine**	**Bowel or rectum**	**Vagina or pelvis**
1. Ability to do household chores (cooking, housecleaning, laundry?) 0 1 2 3			
2. Ability to do physical activity such as walking, swimming or other exercise? 0 1 2 3			
3. Entertainment activities such as going to a movie or concert? 0 1 2 3			
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home? 0 1 2 3			
5. Participating in social activities outside your home? 0 1 2 3			
7. Feeling frustrated? 0 1 2 3			

Physician Initial: _____

The following is a list of questions about you and your partner's sex life. Please circle "Yes" or "No". While answering the questions, consider sexuality in the last 3 MONTHS.

1. Are you sexually active? Yes No
2. Do you want to be sexually active again? Yes No Maybe Never
2. If so, do you have pain with intercourse? Yes No
3. If you are NOT sexually active is it because of:

Partner issues? Yes No
A condition that you are seeing us for? Yes No
A surgery that has resulted in pain preventing you from having sex? Yes No
Other reasons? _____

Any other sexual function questions or concerns?
□ yes □ no

Review of systems: Circle any recurring or persistent problems that you have experienced in the past 2 months:

Constitutional:

Activity change	Yes	No
Appetite change	Yes	No
Chills	Yes	No
Fatigue	Yes	No
Fever	Yes	No
Unplanned weight change	Yes	No

Head, Ear, nose, and throat:

Dental problem	Yes	No
Hearing loss	Yes	No
Mouth sores	Yes	No
Trouble swallow	Yes	No

Eyes:

Eye Pain	Yes	
No		
Blurred vision	Yes	No
Double vision	Yes	No

Skin:

Discoloration	Yes	No
Rash	Yes	No
Persistent itch	Yes	No
Wound	Yes	No

Endocrine:

Too cold	Yes	No
Too hot	Yes	No

Blood:

Easy bruising	Yes	No
Easy bleeding	Yes	No
Big glands	Yes	No

Allergies/Immuno

Env. allergies	Yes	No
Food allergies	Yes	No
Immunocompromised	Yes	No

Lungs or respiratory:

Apnea	Yes	No
Chest tightness	Yes	No
Choking	Yes	No
Frequent cough	Yes	No
Short of breath	Yes	No
Wheezing	Yes	No

Cardiovascular:

Chest pain	Yes	No
Leg swelling	Yes	No
Palpitations	Yes	No

Intestinal:

Abdominal pain	Yes	No
Anal bleeding	Yes	No
Blood in stool	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Nausea	Yes	No
Rectal pain	Yes	No
Vomiting	Yes	No
Heartburn	Yes	No
Fecal urgency	Yes	No
Fecal incontinence	Yes	No

Urogynecology

Burning w/urination	Yes	No
Urinary frequency	Yes	No
Urinary urgency	Yes	No
Urinary incontinence	Yes	No
Night-time urinating	Yes	No
Bedwetting	Yes	No
Difficult urinating	Yes	No
Not emptying bladder	Yes	No
Slow urine flow	Yes	No
Decreased urine	Yes	No
Blood in urine	Yes	No
Pain over kidney	Yes	No
Pelvic pain	Yes	No
Pain with intercourse	Yes	No
Menstrual problem	Yes	No
Vaginal pain	Yes	No
Vaginal bulge	Yes	No
Vaginal bleeding	Yes	No
Vaginal discharge	Yes	No
Vaginal itch	Yes	No
Vulva itch/burn	Yes	No
Genital sore	Yes	No

Muscle/Joints:

Arthritis	Yes	No
Back pain	Yes	No
Gait problem	Yes	No
Muscle pain	Yes	No

Neurologic:

Dizziness	Yes	No
Face different	Yes	No
Headache	Yes	No
Numbness	Yes	No
Seizures	Yes	No
Speech diff.	Yes	No
Tremors	Yes	No
Weakness	Yes	No

Psychologic:

Confusion	Yes No
Depression	Yes No
Anxiety	Yes No
Sleep disturbance	Yes No

Physician Initial: _____

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Fax: 623-271-9229
www.starclinic.org

Patient Information

Print Legibly (PLEASE FILL IN ALL BLANKS)

Patient Name (Last, First, Middle)	**If patient is a minor: Parent/Guardian, Responsible Party**		
Birth Date:	**Social Security #:**		
Ethnicity: (Required for certain labs)			
Street Address:	**City:**	**State:**	**Zip:**
Best daytime # ( ) [Hm]-[cell]-[wk]	**Alternate# ( )** [Hm]-[cell]-[wk]		
Pharmacy Name/ Major Cross streets /City	**E-Mail:**	**Marital status:**	
Patient's Employer:	**Employer's Phone #:**		
Primary Care Physician:	**Phone#:**	**Address:**	
Emergency Contact: Name:	**Home#:**		
Relationship:	**Other#:**		

Primary Insurance

Insurance Name:	**Policyholder's Name:**	**D.O.B:**
Relationship to patient:	**Policyholder's Employer:**	
Policy ID number:	**Group number:**	**Ins phone #:**

Secondary Insurance

Insurance Name:	**Policyholder's Name:**	**D.O.B:**
Relationship to patient:	**Policyholder's Employer:**	
Policy ID number:	**Group number:**	**Ins phone #:**

SIGN:_____ **DATE:**_____

Minor Information

A parent or legal guardian must accompany a minor patient on her first visit to our office so that we can obtain a signature to treat the minor patient. A minor may be treated on subsequent visits without a parent or guardian, if we have the written permission. The adult accompanying the minor patient is responsible for payment of the services at the time of the visit.

Authorization To Treat A Minor

I, _____**, being the parent or legal guardian of the minor child,** _____
do hereby authorize the provider to treat the above mentioned minor.

IN OFFICE ONLY

Eff date:	Co-pay:	Contact/Ref#:

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DISCLOSING INFORMATION FOR FAMILY, FRIENDS, AND OTHERS

[ ] I authorize disclosure of my medical information to the following person(s)

_____ _____

_____ _____

[ ] DO NOT disclose my medical information to anyone (family member, other relatives, close personal friends or others)

Patient Name (Print) **Date**

_____ _____

Patient Signature **Date**

_____ _____

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Patient Financial Responsibility

Star Clinic Urogynecology accept cash, Visa, Master Card, Discover and American Express as forms of payment. **We DO NOT accept personal checks**. Please remember that it is the patient's responsibility to find what their insurance benefits are and if referral is required to see any of our providers. If you have concerns regarding your insurance coverage, please call the number on the back of your insurance card for a full explanation of coverage. Our financial policy is as follows:

Insurance Co-Payments: Must be paid at the time services are rendered.

Deductibles/Co-Insurance: If your deductible has not been met, full payment of the deductible will be required at the time of service along with any applicable co-insurance.

Private Pay/Non-Contracted Insurance Companies: If you do not have insurance coverage or have coverage with insurance we are not contracted with, you will be responsible for payment in full at time services are rendered.

Collection Policy: If your account is placed with a collection agency, all future visits will require payment in full at the time of service. You will be held fully accountable for any collection agency fees and/or attorney fees that are acquired in the recovery of the debt.

Laboratory Services: Laboratory services will be billed by the lab to which were sent. We bill your insurance for specimen collection only. You may receive a bill from the lab for any uncovered services, co-insurance or deductible that may be due. Not all laboratories tests are covered by the insurance company. It is patient's responsibility to see if a test is covered or not.

It is very important to stay well informed about your insurance coverage. If you have new insurance, it is your responsibility to provide us with an updated card. You will be held responsible for the total amount of any unpaid claims/denials for incorrect insurance information.

Signature of patient/guarantor _____

Print name of patient/guarantor _____

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HIPAA COMPLIANCE PATIENT CONSENT FORM

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under law. You ascertain that by your signature that you have reviewed our ntice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1966) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations,
- The practice reserves the right to change the privacy policy as allowed by law,
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions,
- The practice has the right to revoke this consent in writing at any time and all full disclosures will then cease,
- The practice may condition receipt of treatment upon execution of this consent

May we phone, email, or send a text to you to confirm appointments? **YES NO**

May we leave a message on your answering machine at home or on your cell phone? **YES NO**

May we discuss your medical condition with any member of your family? **YES NO**

If **YES**, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____