Department of Urology  New Patient Intake Form—Female

Last Name______________________ First Name___________________________
Date of Birth: ____/____/____ Social Security Number:___________________
Referring Physician:________________________________________ Phone #: _________________________
Physician Address: __________________________________________________________________________

History of Present Illness
Please answer the following questions

Chief Complaint
What is the main reason for your visit today?
☐ Bladder Cancer
☐ Urinary Tract Infections
☐ Renal Cyst/ Mass
☐ Urinary Frequency
☐ Other: ____________________________

Which symptoms best describe you? Check all that apply.

☐ Frequent Urination—day, night, or both
☐ Sudden or strong urge to urinate
☐ Leakage with little or no warning-----sometimes unable to make it to the bathroom in time
☐ Unable to completely empty the bladder-----feels like there is more even after going to the bathroom
☐ Accidental leakage with physical activity—exercising, sneezing, or coughing
☐ Bladder or pelvic pain
☐ Problems with bowel function (if checked, please select symptom below)
   ☐ Accidental loss or leakage of stool
   ☐ Constipation
   ☐ Other
☐ No Bladder or bowel problems

How long have you had these symptoms? __________________________________________

Have you tried medications to help your bladder symptoms? ☐ Yes ☐ No

If yes, how many different medications have you tried? ________________________________

On a scale from 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Circle a number

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Complete Symptom Relief</td>
</tr>
</tbody>
</table>

Are you still taking any of these medications? ☐ Yes ☐ No

If no, why have you stopped taking them?
☐ Did not work as well as expected
☐ Side effects
☐ Expense
☐ Interaction with other medications
☐ Other

If side effects or other checked, please explain: ____________________________________________

Behavior modifications tried? _____________________________________________________________

(I.e., reduced fluid intake, caffeine reduction, Kegel exercises, physical therapy, or lifestyle changes)

On a scale from 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bladder control symptoms? Circle a number

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Frustrated</td>
<td>Complete Frustration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1


**Urogenital Distress Inventory Short Form (UDI-6)**

Please answer each question by checking the best response. While answering these questions, please consider your symptom over the last 3 months. We realize that you may not be having problems in some of these areas, but please fill out this form as completely as possible.

<table>
<thead>
<tr>
<th>Do you experience, and if so, how much are you bothered by ...</th>
<th>Not at all</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Greatly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent Urination</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Leakage related to feeling of urgency</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Leakage related to physical activity, coughing, or sneezing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Small amounts of leakage (drops)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Difficulty emptying bladder</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Pain or discomfort in lower abdominal or genital area</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**INCONTINENCE IMPACT QUESTIONNAIRE—SHORT FORM (IIQ-7)**

Some people find accidental urine loss may affect their activities, relationships, and feelings. The questions below refer to areas in your life that may have been influenced or changed by your problem. For each question, circle the response that best describes how much your activities, relationships, and feelings are being affected by urine leakage.

<table>
<thead>
<tr>
<th>Has urine leakage affected your ...</th>
<th>Not at all</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Greatly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ability to do household chores (cooking, housecleaning,</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>laundry)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Physical recreation such as walking, swimming,</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>or other exercise?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Entertainment activities (movies, concerts, etc.)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Ability to travel by car or bus more than 30 minutes from</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>home?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Participation in social activities outside your home?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Emotional health (nervousness, depression, etc.)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling frustrated?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Items 1 and 2 = physical activity; Items 3 and 4 = travel
Items 5 = social/relationships; items 6 and 7 = emotional health

**Scoring:** Item responses are assigned values of 0 for “not at all,” 1 for “slightly,” 2 for “moderately,” and 3 for “greatly.”

The average score of items responded to is calculated. The average, which ranges 0 to 3, is multiplied by 33 1/3 to put scores on a scale of 0 to 100.

Medical History
Please check if you have ever had any of the following:

- Parkinson’s
- Multiple Sclerosis
- Heart Disease
- Heart Attack
- High Blood Pressure
- Lung (COPD, Asthma)
- High Cholesterol/triglyceride
- Sexually transmitted disease
- Stroke/TIA
- Diabetes
- Thyroid
- Seizures/Epilepsy
- Cancer: Type
- Kidney/Bladder (Renal Cyst, Renal Mass, Stones)
- Anxiety, depression or mental illness
- Blood disorders (abnormal bleeding anemia, high or low white count)
- Other

Are you pregnant? Y / N
How many Pregnancies? _____ How many children? _____
Vaginal _____ C-section_____ Date of last menstrual period: ___________

Surgical History
1. Have you ever had surgery? ☐ Yes ☐ No
2. Please list approximate dates and reasons for any surgery (including childbirth):
   Date Surgeries
   ________________________________
   ________________________________
   ________________________________
   ________________________________
   ________________________________
   ________________________________

Medications
1. Please list any prescription medications you are currently taking and their dosages.

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Reason for taking</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medications cont.
2. Please indicate if you are taking the following over the counter medications:
   - Aspirin
   - Tylenol
   - Advil/Motrin/Ibuprofen
   - Antacid
   - Laxatives
   - Decongestants
   - Antihistamines
   - Vitamins/Mineral Supplements
   - Other: __________________        ______________

Pharmacy
Pharmacy Name: ___________________________
Pharmacy Address: ________________________________
Pharmacy Phone Number: ___________________________

Allergies
Do you have any allergies? ☐ Yes ☐ No
If yes please specify below:
_________________________ ________________
_________________________ ________________
_________________________ ________________
_________________________ ________________

Social History
Occupation: ________________________________
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow
Do you smoke? ☐ Yes ☐ No
How much? __________________
How Long? __________________

Do you drink alcohol? ☐ Yes ☐ No How Much?
   - Beer __________________
   - Wine __________________
   - Liquor __________________

Do you drink Caffeine? ☐ Yes ☐ No How Much?
   - Coffee __________________
   - Tea __________________
   - Soda __________________

Are you on a special diet? ☐ Yes ☐ No
If yes please Specify: ________________________________

Family History
Please list all serious illnesses in your immediate family;
(Example: Diabetes, Cancer, Tuberculosis, Heart disease)
Mother: Age_____ ☐ Living: _____________________________
   ☐ Deceased- Cause: ________________________________
Father: Age_____ ☐ Living: _____________________________
   ☐ Deceased-Cause: ________________________________
Sister: ________________________ ________________
Brother: ________________________ ________________
**Constitutional Symptoms**
- Fever Y|N
- Chills Y|N
- Sweats Y|N
- Weakness Y|N
- Fatigue Y|N

**Eyes**
- Blurred Vision Y|N
- Double Vision Y|N
- Pain Y|N

**Immunologic**
- Recurrent Fevers Y|N
- Recurrent Infections Y|N
- Malaise Y|N

**Neurological**
- Confusion Y|N
- Numbness/Tingling Y|N
- Dizzy Spells Y|N
- Headache Y|N

**Endocrine**
- Excessive Thirst Y|N
- Too hot/Cold Y|N
- Excessive Hunger Y|N

**Gastrointestinal**
- Abdominal Pain Y|N
- Nausea/Vomiting Y|N
- Indigestion/heartburn Y|N
- Diarrhea Y|N

**Cardiovascular**
- Chest Pain Y|N
- Palpitations Y|N
- Ankle Swelling Y|N

**Integumentary**
- Skin Rash Y|N
- Boils Y|N
- Persistent itch Y|N
- Burns Y|N
- Skin Lesion Y|N

**Musculoskeletal**
- Joint pain Y|N
- Neck Pain Y|N
- Back Pain Y|N

**Ears/Nose/Throat/Mouth**
- Ear Infection Y|N
- Sore Throat Y|N
- Sinus Problems Y|N

**Genitourinary**
- Urine Retention Y|N
- Painful Urination Y|N
- Urinary Frequency Y|N
- Blood in Urine Y|N

**Respiratory**
- Wheezing Y|N
- Frequent Cough Y|N
- Shortness of breath Y|N

**Hematologic/Lymphatic**
- Swollen glands Y|N
- Blood clotting problems Y|N
- Bruising tendency Y|N

**Psychologic**
- Depression Y|N
- Anxiety Y|N

Physician Signature: ___________________________
Date: ________________________
Department of Urology New Patient Intake Form—Female

Ambulatory Care
Consent and Notice of Privacy Practices
Acknowledgement Form

Patient Name: ___________________ Date of Birth: _____________
MRN: ___________________ Enc#: _____________

By signing below I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the Hospital and its staff. I have been provided a copy of the SBOHCA Joint Notice of Privacy Practices (Notice) and have therefore been advised of how health information about me may be used and disclosed by the Hospital and the facilities listed at the beginning of the Notice, and how I may obtain access to and control this information.

I acknowledge the receipt of the Ambulatory Care Patient Guide on, or prior to this visit.

Signature of Patient or Patient Representative

Print Name of Patient or Personal Representative

Relationship, if signed by person other than Patient

Date _____________ Time _____________

Signature of Witness _____________ Print Name of Witness _____________
Date _____________ Time _____________
Ambulatory Care
Authorization to Discuss PHI with a Designee

Patient’s Name: __________________________ Date of Birth: __________________________
(Please Print Clearly) (Please Print Clearly)

By signing below I hereby give permission to ________________________________
(Name of Physician, Physician Practice or Service Practice)

to discuss with the following individuals information related the health care services I receive at the
above named physician’s office/physician practice. I agree that this information will be limited to
appointment scheduling (date and time), procedure scheduling (date, time and preparation
information) prescription re-fill(s), laboratory test results, radiology examination results and billing
inquiries. I agree that this does not include the ability for the individuals noted below to authorize
the disclosure of my protected health information to a third party or to request on my behalf a copy
of my health information. I agree that this authorization will remain active until I revoke it by
submitting an updated authorization to the physician practice noted above.

Name of Individual __________________________ Relationship to patient __________________________

Name of Individual __________________________ Relationship to patient __________________________

Name of Individual __________________________ Relationship to patient __________________________

Name of Individual __________________________ Relationship to patient __________________________

Name of Individual __________________________ Relationship to patient __________________________

Name of Individual __________________________ Relationship to patient __________________________

Name of Individual __________________________ Relationship to patient __________________________

Signature of Patient __________________________

Date ________________ Time ________________

For Office Use Only

Patient’s MRN __________________________

Date received: __________________________

This form is for office use only. Place in the correspondence section of the medical record. Not for release or disclosure.