# HENDRICKS UROGYNECOLOGY

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Hendricks Regional Health MEDICAL GROUP

Welcome to Hendricks Urogynecology, please fill out the following questions so we can better serve you during your visit with us. If you have any questions please reach out to one of our team members so we can assist you. Office number: 317-386-5632.

Name: _____Date of Birth: _____
Phone Number: _____
Email address: _____
Address: _____
City: _____ State: _____ Zip: _____

**Reason for your visit? (Check all that apply):**

☐ Urinary incontinence (leaking urine)
☐ Leakage with activity (Sneeze, cough, run, jump, laugh)
☐ Leakage with urgency (can't make it to the bathroom in time)
☐ Urinary urgency (gotta go gotta go feeling)
☐ Urinating at night (more than once)
☐ Pelvic prolapse (bulge or protrusion in the vagina)
☐ Constipation or difficulties with bowel movements
☐ Anal incontinence (problem with bowel control or leaking stool)
☐ Pelvic pain
☐ Hematuria (blood in the urine)
☐ Recurrent urinary tract Infections (more than 3 positive cultures in a year)
☐ Fistula
☐ Other symptoms you would like to share:

_____
_____
_____

**Have you had Urogynecology treatments before?** ☐ Yes ☐ No
If yes, Who did you see? _____

Previous urogyn surgeries/procedures: (include procedure, date and hospital)

_____
_____
_____

Have you ever used any of the following medicines to help control your bowels or bladder?

☐ Overactive bladder medications: _____
☐ Bladder botox
☐ Vaginal estrogen
☐ Fiber supplements
☐ Stool Softener
☐ Antidiarrheal
☐ Laxatives
☐ Other_____
☐ Antidiarrheal

Do you feel you empty your bladder well? ☐ Yes ☐ No
How often do you go to the bathroom to void (pee) while awake: every _____ hours
How many times do you get up at night to void (pee): _____
Do you use pads for leakage ☐ Yes ☐ No
If yes, how many do you use per day? _____, how many at night _____?

What city do you live in? _____
What do you do for work? _____
If you are retired, what did you previously do for work? _____

How did you hear about us?

☐ Referral
If so, who: _____
☐ Pelvic Floor Physical Therapy
☐ Family member or friend
☐ Insurance Directory
☐ Facebook
☐ Instagram
☐ Google Search
☐ Brochure / Billboard
☐ Other_____

Please describe your sexual activity over the last 5 years (check all that apply):
☐ I had sex with one man only
☐ I had sex with only one woman I had multiple male partners.
☐ I had multiple female partners.
☐ I had both male and female partners.
☐ I did not have any sexual partners.
☐ Other: _____

Are you satisfied with your sex life? ☐ Yes ☐ No
Does it hurt to have sex? ☐ Yes ☐ No

What Pharmacy would you like our office to use:

_____

Number of children you have _____ Number of pregnancies_____
Pregnancy outcomes: ___vaginal delivery, __ cesarean section, __ ectopic

Date of last period: _____ (month and year)
Are/were your periods regular (once per month)? ☐ Yes ☐ No

Date of last pap smear (cervical cancer screening)?_____ (year)
Have you had any abnormal pap smears in the past? ☐ Yes ☐ No ☐ Unsure

Date of last colonoscopy? _____ (year) or ☐ I have never had one
Have you ever had an abnormal colonoscopy? ☐ Yes ☐ No

Are you a current nicotine user? ☐ Yes ☐ No

If yes, Check all that apply: ☐ cigarettes ☐ cigar ☐ vape ☐ hookah ☐ chew

If yes, how much do you use per day_____

Have you ever considered quitting? _____

Do you have a history of smoking? ☐ Yes ☐ No

If yes, when did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much and how often: _____

Have you ever been a victim of abuse? ☐ Yes ☐ No

What is your current gender identity?

☐ Female/woman
☐ Male/man
☐ Transgender Female/woman, MTF (male-to-female)
☐ Transgender male/man, FTM (female-to-male)
☐ Gender Queer - neither exclusively (male nor female)
☐ Prefer not to answer
☐ Additional category_____

What sex were you assigned at birth on your birth certificate?

☐ Female ☐ Other_____
☐ Male

What pronouns do you prefer?

☐ She/her/hers ☐ Other: _____
☐ He/him/his
☐ They/them/theirs

**Use this space to type any other information you would like the doctor to know before your visit. This can include your needs for a translator, use of a wheelchair, coordination with a health care facility, or just personal information you think would be helpful.**

_____

_____

_____

_____

_____

_____

**Past Medical History**

| Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|
| History of blood clots | | | Depression | | |
| Stroke | | | Anxiety | | |
| Heart attack | | | Arthritis | | |
| Heart valve disorder | | | High cholesterol | | |
| High blood pressure | | | History of blood transfusion | | |
| Diabetes | | | Thyroid disease | | |
| Cancer | | | History of breast cancer | | |
| Reaction to anesthesia | | | If yes, are you in chemo now? | | |
| COPD | | | Chronic Kidney Disease | | |
| Obstructive sleep apnea | | | Kidney Stones | | |
| Asthma | | | Hematuria (blood in urine) | | |
| Chronic pain | | | Liver Disease | | |

Other: _____

**Medications (Name of medication, reason for taking and dose)**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

**Past Surgical History (Year and type of history)**

_____ _____

_____ _____

_____ _____

_____ _____

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |

**We look forward to caring for you at Hendricks Urogynecology.**

- **Please bring out this paperwork filled out to your first appointment.**
- **You can also email it to urogynecology@hendricks.org.**
- **If you have documents from prior doctor visits that are relevant to your current pelvic floor concern please bring these with you to your first appointment.**
- **Please come to your first appointment with a comfortably full bladder.**

**Please feel free to call us with any questions or concerns.**

**Office Address:**
Hendricks Urogynecology
100 Hospital Lane, suite 145, Danville, IN 46122
Office number: 317-386-5632
Fax number: 317-386-5633