Atlantic
Health System

ATLANTIC UROGYNECOLOGY ASSOCIATES NEW PATIENT PACKET

Dear Patient: Please print and fill out the attached new patient packet.

PATIENT'S NAME:

ALLERGIES (Please list your medication allergies and reactions)

_____

_____

_____

_____

PREFERRED PHARMACY

NAME _____ PHONE NUMBER_____

ADDRESS_____

MEDICAL CONDITIONS

PLEASE LIST YOUR ONGOING MEDICAL CONDITIONS BELOW

_____

_____

_____

_____

_____

_____

_____

_____

_____

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PLEASE LIST ALL YOUR PRIOR SURGICAL PROCEDURES:

DATE	SURGICAL PROCEDURES (PRIOR)

DATE OF LAST PAP SMEAR:

HAVE YOU HAD ANY ABNORMAL PAP SMEAR? YES / NO

DATE OF LAST MAMMOGRAM?

HAVE YOU HAD ANY ABNORMAL MAMMOGRAMS? YES/ NO

DATE OF LAST COLONOSCOPY:

HAVE YOU HAD ANY ABNORMAL COLONOSCOPIES? YES/ NO

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OUTPATIENT / MULTIPLE VISITS MEDICATION RECONCILIATION FORM

Name:	Allergic To / Describe Reaction:
Date of Birth:	Primary Care Provider: Phone #: Fax#:

Information Source: ☐ Patient/Family ☐ Rx bottles ☐ List of medication ☐ Physician / Physician Office ☐ Pharmacy

Date started	Medication	Dose	Route	How often	Reason For taking	Discontinued Date

Managing your Medication is Important to your Healthcare

- ✓ **Maintain a list** of your medication information.
- ✓ **Carry** medication **information** at all times in case of emergency.
- ✓ **Update the medication** list when medications are discontinued, doses are changed or new medications are added, include over the counter medications taken regularly.
- ✓ **Give** an updated list of medications **to your Primary Care Physician** as needed, especially after discharge from the hospital or seeing another physician.
- ✓ **Share** this **medication list** with all healthcare providers.

Medication list has been reviewed and revised as necessary. Copy to patient if changes made.

Date	Time	Int	Date	Time	Int	Date	Time	Int	Date	Time	Int	Date	Time	Int

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PATIENT QUESTIONNAIRE

Date of Appointment: _____

Last Name: _____ First Name: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Number of Pregnancies: _____ Number of Vaginal Births: _____ Number of C-Sections: _____

Weight of Largest Baby: _____ Form of Birth Control: _____ Date LMP: _____ Age at Menopause: _____

Do you smoke? ☐ yes ☐ no _____packs per day Do you drink alcohol? ☐ yes ☐ no _____drinks per day

Listed below are a series of questions regarding your bowel, bladder or pelvic symptoms, as well as your degree of discomfort, if any. Using the "key" - in the gray box - please place an **X** next to the appropriate number for each question below. While answering these questions, please consider your symptoms **over the last 3 months**.

KEY:
1 - Not at All
2 - Somewhat
3 - Moderately
4 - Quite a Bit

1. Do you experience pressure in the lower abdomen? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

2. Do you experience heaviness or dullness in the pelvic area? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

4. Do you have to push on the vagina or rectum to complete a bowel movement? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

5. Do you experience a feeling of incomplete bladder emptying? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

6. Do you have to push up on a bulge in the vaginal area to start/complete urination? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

7. Do you feel you need to strain too hard to have a bowel movement? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

8. At the end of a bowel movement, do you feel you have not completely emptied your bowels? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

9. If your stool is well formed, do you lose stool beyond your control? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

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PATIENT QUESTIONNAIRE

KEY:
1 - Not at All
2 - Somewhat
3 - Moderately
4 - Quite a Bit

10. If your stool is loose or liquid, do you lose stool beyond your control? ☐ yes ☐ no
    If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

11. Do you lose gas from the rectum beyond your control? ☐ yes ☐ no
    If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

12. Do you have pain when you pass your stool? ☐ yes ☐ no
    If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement? ☐ yes ☐ no
    If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

14. Does a part of your bowel ever pass through your rectum and bulge outside, during, or after a bowel movement? ☐ yes ☐ no
    If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

15. Do you usually experience frequent urination? ☐ yes ☐ no
    If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

16. Do you experience urine leakage associated with a strong sensation of needing to go to the bathroom? ☐ yes ☐ no
    If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

17. Do you experience urine leakage related to coughing, sneezing, or laughing? ☐ yes ☐ no
    If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

18. Do you experience small amounts of urine leakage (that is drops)? ☐ yes ☐ no
    If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

19. Do you experience difficulty emptying your bladder? ☐ yes ☐ no
    If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

20. Do you experience pain or discomfort in the lower abdomen or genital region? ☐ yes ☐ no
    If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

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