



850 East Harvard Ave Suite 475, Denver, CO 80210. (303) 282-0006 Fax (303) 282-0066

Patient Information *Please fill out completely*

Appointment Date _____

Last _____ First _____ M.I. _____ Date of Birth _____

Social Security # _____ Marital Status _____ Gender _____

Address _____ (City/State/Zip) _____ Home Phone _____ Alt. Phone _____

Employment Information

Employer _____ Address _____ Occupation _____

Business Phone _____ EXT. _____ (City/State/Zip) _____

Physician Information

Referring Physicians Name _____ Address _____ (City/State/Zip) _____ Phone _____

Primary Physicians Name _____ Address _____ (City/State/Zip) _____ Phone _____

How did you hear about us? _____

Preferred Pharmacy Information

Pharmacy Name _____ Address _____ (City/State/Zip) _____ Phone _____

Insurance Information: Please fill out completely regardless of us copying your insurance card(s)

Please Note: If you have a Medicare Card along with other Insurance make sure you bring your Medicare card with you to your appointment.

Primary Medical Insurance _____ **Effective Date** _____

ID# _____ Group# _____

Address _____ (City/State/Zip) _____ (Phone) _____

Policy Holder Name _____ Relationship _____ ID# _____ Insured Date of Birth _____

Does your Insurance require a referral? ___ Yes ___ No Co-Payment Amount (Specialist) \$ _____

Deductible ___ Yes ___ No Amount \$ _____

Secondary Medical Insurance: _____ **Effective Date:** _____

ID# _____ Group# _____

Address _____ (City/State/Zip) _____ (Phone) _____

Policy Holder Name _____ Relationship _____ ID# _____ Insured Date of Birth _____

Does your Insurance require a referral? ___ Yes ___ No Co-Payment Amount (Specialist) \$ _____

Deductible ___ Yes ___ No Amount \$ _____

HIPAA Approved Contacts (anyone that can speak on your behalf regarding your health info in case of an emergency).

I. _____

Last _____ First _____ M.I. _____ Birthdate _____ Gender _____

Birthdate _____ Relationship _____

Address _____ City _____ State _____ Home Phone _____

II. _____

Last _____ First _____ M.I. _____ Birthdate _____ Gender _____

Birthdate _____ Relationship _____

Address _____ City _____ State _____ Home Phone _____

PAYMENT TERMS AND AGREEMENTS

I, the undersigned, in consideration for services rendered to me by Foothills Urogynecology, understand and agree to the following:

1. Any co-payments are required to be paid on the day services are rendered.
2. Payment for charges is due on the date of service with the exception of insurance carriers for which Foothills Urogynecology is under contract to file directly. Cosmetic procedures must be paid in full two weeks prior to surgery.
3. My insurance coverage may not provide payment for all charges incurred in obtaining treatment from Foothills Urogynecology. I will be responsible for any co-payment, deductible, coinsurance, or service not covered by my insurance provider. If I do not have insurance coverage for services rendered by Foothills Urogynecology, I agree to pay all charges resulting from such services on the day of service.

Please Note: If you have a Medicare Card along with other Insurance make sure you bring your Medicare card with you to your appointment.

4. As a patient it is my responsibility to verify with my insurance company that Foothills Urogynecology is a part of my provider network (HMO, PPO, etc.). I understand it is my responsibility to obtain visit referrals from my primary care physician (PCP) if my plan requires such. I understand that I am responsible for notifying the office of any changes in insurance coverage, address or phone number(s). Failure to notify Foothills Urogynecology of these changes will make me responsible for claims not accepted by the insurance company.
5. I hereby authorize Foothills Urogynecology to file with my insurance carrier, and I assign payment of medical benefits to Foothills Urogynecology and in addition I authorize release of any and all medical records and information necessary to process any claim generated by services I receive from Foothills Urogynecology.
6. I authorize the office and or its employees to release any and all medical records and information necessary for treatment, payment and operational purposes as indicated in Foothills Urogynecology's Notice of Privacy Practices.
7. Please note that we only use your Social Security Number for billing purposes only.

CONSENT FOR TREATMENT

I, the undersigned, voluntarily agree to the tests, procedures, and/or treatments which the physician has deemed necessary and which are administered to or performed on me under the direction of the physician or his/her designee.

CONSENT TO RELEASE MEDICAL RECORDS

1. I understand that my insurance carrier, short and long term disability insurance may require copies of my medical records in order to process claims. I hereby agree to such release of my records.
2. I understand that in the course of its own business Foothills Urogynecology staff members will have access to my medical record. I hereby agree to such sharing of my personal health information.

CONSENT TO COMMUNICATE MEDICAL RESULTS

Persons with whom Foothills Urogynecology may discuss my medical condition (other than for purposes of treatment, payment or operations):

Name _____

Date _____

Signature _____

Date _____

A photocopy of these assignments shall be as valid as the original. Please attach all pertinent insurance ID cards for photocopying.



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Patient Questionnaire: *Please fill out completely*

Name _____ Date of Birth _____ Age _____

Current Method of Birth Control _____



Please briefly describe the reason(s) that you are being seen in our office



For how long have you experienced this problem?



Please list any previous tests or treatments for this condition

Preferred Pharmacy Information

Pharmacy Name

Address

(City/State/Zip)

Phone

†UROGYNECOLOGIC SYMPTOM QUESTIONNAIRE

How long have you been experiencing this problem? _____

During an average day, I urinate _____ times/day and _____ times/week.

I usually urinate every _____ hours during the day.

At night, I get up _____ times to urinate.

- | | | | | |
|--------|---|---------|----------|------------|
| I. | What amount of urine do you lose? | Small | Large | Both |
| II. | What position do you lose urine? | Sitting | Standing | Lying down |
| III. | Do you wear a pad all of the time?
If so how many per day? _____ | | NO | YES |
| | When you change your pads are they? | Dry | Damp | Wet |
| IV. | Do you lose urine in spurts with laughing,
coughing, sneezing, or exertion? | | NO | YES |
| V. | Do you have a severe sense of urgency
before losing urine? | | NO | YES |
| VI. | Do you experience urine leakage without knowing it? | | NO | YES |
| VII. | Does the sound, sight, or feel of running
water cause you to lose urine? | | NO | YES |
| VIII. | Can you voluntarily stop the urine? | | NO | YES |
| IX. | Do you wet your bed at night? | | NO | YES |
| X. | Do you loose urine as a constant drip? | | NO | YES |
| XI. | Is it painful or crampy to pass or lose urine? | | NO | YES |
| XII. | Do you feel that you are able to empty
your bladder completely when you sit down to urinate? | | NO | YES |
| XIII. | After urinating you feel: _____Empty _____Still have the sensation to urinate. | | | |
| XIV. | Is it difficult to get the urine stream started? | | NO | YES |
| XV. | Does your urine stream seem weak or slow? | | NO | YES |
| XVI. | Do you feel as if your pelvic organs are falling
down or can you feel a bulge at the opening of your vagina? | | NO | YES |
| XVII. | Have you ever had blood in your urine? | | NO | YES |
| XVIII. | Do you have frequent urinary tract infections? | | NO | YES |

Bowel Symptoms

I move my bowels _____ times/day and _____ times/week.

I. Do you experience?	Constipation	Diarrhea
II. Do you experience loss of stool?	NO	YES
III. Do you have blood in your stools?	NO	YES
IV. Do you experience regular bowel movements?	NO	YES
V. Do you experience difficulty emptying your rectum?	NO	YES
VI. Do you have to “strain” during a regular bowel movement?	NO	YES
VII. Do you feel pressure in your vaginal region?	NO	YES
VIII. Do you experience Digital Defecation? (Having to manually push stool out)	NO	YES
IX. Do you have problems controlling gas?	NO	YES

Please list any other questions or concerns particularly related to urine or stool loss (not listed above)?

† INDIVIDUAL INCONTINENCE IMPACT QUESTIONNAIRE

Please complete the following questionnaire if applicable to your situation

My bladder control problem affects my *(Please place a check after each appropriate statement)*

- I. Ability to do household chores (washing dishes, cleaning house, etc.).
 not at all rarely frequently all of the time not applicable
- II. Ability to socialize and interact with friends and colleagues.
 not at all rarely frequently all of the time not applicable
- III. Quality and quantity of sleep.
 not at all rarely frequently all of the time not applicable
- IV. Performance of routine exercise or participation in sports (walking, jogging etc.).
 not at all rarely frequently all of the time not applicable
- V. Personal and intimate relationships (including hugging and sexual intercourse).
 not at all rarely frequently all of the time not applicable
- VI. Ability to participate in entertainment activities
 not at all rarely frequently all of the time not applicable
- VII. Ability to perform my job.
 not at all rarely frequently all of the time not applicable
- VIII. Ability to wear the clothes I want.
 not at all rarely frequently all of the time not applicable
- IX. Ability to go places I want to go.
 not at all rarely frequently all of the time not applicable

Please list an activity (not listed above) which is particularly affected by your urine loss:

GYNECOLOGIC HISTORY

First day of last period _____ Number of days between periods _____
Current method of birth control _____ Past methods of birth control _____
Age at first period _____

Date of last Pap Smear? _____ Normal? _____
History of Abnormal Pap? _____
Date of last Mammogram? _____ Normal? _____
How many days does your period usually last? _____
Do you have bleeding or spotting between periods? _____

Please check if you have had or currently have any of the following infections

_____ Yeast _____ Trichomonas _____ Chlamydia _____ Gonorrhea
_____ Herpes _____ HPV _____ HIV _____ MRSA _____ Other

SEXUAL HISTORY

_____ Satisfactory _____ Uncomfortable _____ Wish to Discuss

OBSTETRICAL HISTORY

Number of pregnancies _____ Miscarriages _____ Abortions _____ Living Children _____

Did you have an episiotomy? _____

Did you have Gestational Diabetes? _____

Did you have Pre-eclampsia/Toxemia during pregnancy? _____

Baby Birth Weight	Type of Delivery

SOCIAL HISTORY

Tobacco: _____ YES _____ NO Current Use _____ YES _____ NO

Type and amount: _____ For how long? _____

Alcohol: _____ YES _____ NO How many ounces per week? _____

Caffeinated beverages: _____ YES _____ NO Type and amount _____

Street drugs: _____ YES _____ NO Type and amount _____

Do you do any type of exercise? If so what type(s) _____

SUGERIES AND HOSPITALIZATIONS

List any surgeries and serious illnesses which required hospitalization (excluding pregnancy).

Surgery/Hospitalization

Date

MEDICATIONS

List all medications you currently take, with dosage and frequency, including over-the-counter-drug.

Medication

Dosage

How often taken

Herbal Supplements/Vitamins

List all supplements you are currently taking.

Name

Dosage

How often taken

DRUG ALLERGIES INCULDING LATEX, IV DYE, IODINE OR ADHESIVES

List all drugs you are allergic to and the allergic reaction to each drug

Drug

Reaction

PAST/PRESENT MEDICAL HISTORY PATIENT ONLY

*Please note if **you** have been diagnosed with any of the following conditions*

Condition/Disorder/Disease	YES	NO	Please Explain
Allergies, Immune & Infectious Problems (hay fever, seasonal allergies, HIV, Lupus etc...)			
Blood & Lymph Node (Anemia, Blood Clot/Transfusion, bleeding disorder)			
Bones/Joints and Muscles (Arthritis etc...)			
Cancer			
Cardiovascular (heart problems, chest pains, high blood pressure, stroke, pacemaker, heart surgery, heart disease, high cholesterol)			
Constitutional (chronic cough, fever, weight loss, poor appetite)			
Ear/Nose/Throat (hearing loss, sinus, sore throat, freq bloody noses)			
Endocrine (thyroid or pituitary problems etc...)			
Eyes (eye disease, glaucoma, cataract, lazy eye, retina problems)			
Gastro-Intestinal (heartburn, acid reflux, diarrhea, vomiting, ulcer, IBS etc...)			
Genito-Urinary (urinary problems, blood in urine etc...)			
Gynecological Cancers (ovarian, uterine, endometrial)			
Hematologic (blood disorders, leukemia, easy bleeding/bruising, take aspirin etc...)			
Lungs and Respiratory (asthma, tuberculosis etc...)			
Musculoskeletal (muscle aches, joint pain, swollen joints, artificial joint, arthritis etc...)			
Neurological (numbness, weakness, paralysis, headaches, spasm, seizures, Fibromyalgia, MS etc...)			
Psychiatric (depression, anxiety etc...)			
Respiratory (asthma, shortness of breath, wheezing, coughing)			
Skin (skin rashes, excessive dryness, used accutane, skin cancer/disease etc...)			
Diabetes, radiation treatments, anesthesia problems etc...			
Hepatitis B or C, HIV or AIDS, Tuberculosis etc...			

FAMILY MEDICAL HISTORY
(Please specify *Maternal or Fraternal*)

Please note any blood-related relative has had any of the following conditions

Condition/Disorder/Disease	YES	NO	Please Explain
Breast Disease			
Cardiovascular (heart problems, high blood pressure, stroke, pacemaker, heart surgery, heart disease)			
Diabetes			
Gynecological Cancers (ovarian, uterine, endometrial)			
Hepatitis B or C, HIV or AIDS, Tuberculosis etc...			