Northwell Health
Physician Partners

North Shore-LIJ Health System is now **Northwell Health**

Urogynecology:
Female Pelvic Medicine & Reconstructive Surgery

Harvey Winkler, MD, FACOG
System-Chief of Urogynecology

Dara Shalom, MD, FACOG
Fellowship Program Director
Associate Chief of Urogynecology

Christina Tso, DNP, FNP-BC
Mychal Grodstein, PA
Lauren Serrone, PA

Please complete the forms with your name and date of birth on all pages and bring them with you at the time of your appointment. Thank you.

Name:_____

Your Appointment Date: _____ Your Appointment Time: _____

Seeing: DR. HARVEY WINKLER

We wish to welcome you as a new patient. Enclosed please find various forms we require for your upcoming visit with the doctor. So that we may perform urine testing, please **COME WITH A FULL BLADDER AND DO NOT EMPTY BEFORE THE VISIT.**

Please arrive 15 minutes before your appointment time. You must present your current insurance card, current pharmacy information and photo identification. **If your insurance requires a referral, please obtain your referral from your primary care physician.**

You have the option to receive your 48 hour appointment reminder sent via text message. You can sign up for this appointment reminder by texting the code "NSLIJ" to 622622. Then watch for the confirmation text sent to your phone. Message and data rates may apply.

There is a parking garage underneath the building. There is complimentary valet parking available on Level G2. If you have any further questions, please call the office.

Sincerely,

Urogynecology: Female Pelvic Medicine &
Reconstructive Surgery

UROGYNECOLOGY- WHAT TO EXPECT

NORTHWELL HEALTH

Urogynecology: Female Pelvic Medicine & Reconstructive Surgery

Harvey Winkler, MD **Dara Shalom, MD** **Bertille Gaigbe-Togbe, MD**

Mychal Grodstein, RPA-C Kerry O'Brien-Espinoza, NP
Lauren Serrone, RPA-C

OFFICE LOCATION:

865 NORTHERN BLVD., 2nd FLOOR, SUITE 202
GREAT NECK, NY 11021
Tel: 516-622-5114 Fax: 516-622-5045

We have prepared this information packet to describe the Urogynecology evaluation prior to your appointment. We hope it will answer some of your questions and help you understand the evaluation that is planned.

Please note that we do not see patients for routine gynecological care, i.e., annual pap smears.
This appointment does NOT take the place of your regular yearly GYN visit.

We are always looking to improve the quality of the care we provide to you. You may receive a questionnaire either by conventional mail or via email. Please take the time to give us your feedback so we can move forward with improving your patient experience

*** Please complete the accompanying questionnaire and voiding diary and bring them with you c the day of your appointment.** ***The forms are necessary even if you think your problem is not with the bladder.***

***** PLEASE COME IN WITH A FULL BLADDER AND DO NOT EMPTY*****

*** If you have had an evaluation from another physician, obtain the records and bring them to your appointment.**

**** If you require a referral or consultation request form from your primary care physician, you must bring the form or written consultation request with you. Note: If you require a consultatio request form and do not have one, your insurance cannot be billed for the visit and you will be responsible for full payment. If you are unsure whether you need such a form call our office****

Patient Name: _____ *Date of Birth:* _____

What to Expect

Urogynecology is a subspecialty of gynecology designed to address those patients with bladder problems, genital relaxation (dropping of the bladder, uterus, or other pelvic organs), and pain syndromes. Incontinence (involuntary of urine) can be of several different types and have various causes. In addition, genital relaxation may involve one organ or several organs of the pelvis. The Urogynecology evaluation is specifically designed to distinguish betwee types of incontinence, and types of relaxation problems. Effective treatment is based on the comprehensive assessr of these problems.

During the office visit, a sterile urine specimen will be obtained using a very thin catheter. The physician will spea with you about the specifics of your problem. You will then have a focused physical exam. Your bladder may be f through a thin flexible tube in order to evaluate the bladder's response to filling. This is not painful. If you have a urine control problem, you will be asked to strain and cough in order to provoke urinary leakage. Please understanc that the proper understanding and treatment for your problem requires the problem to be demonstrated in the office. small number of patients may experience very mild irritation during the evaluation but most women do not have *an* discomfort. There are no needles or injections.

After the above evaluation, a specific problem will be identified in about half of all patients, and a treatment plan wi be started. For the other half of patients, sophisticated bladder tests (urodynamics) will be required and you will be asked to return for a subsequent evaluation. A treatment plan will be formulated and your questions will be answere

****Please be advised that initial evaluation fees vary based on your problem. Prior to your visit, it is impossibl to know what tests will be needed. Please contact our office with any insurance questions prior to your visit.**

It is the policy of the Urogynecology Division to see patients in a timely fashion. If you have special needs that we a unaware of (surgery scheduled, transportation constraints, requiring a translator, wheelchair, or other special needs), please let us know. Unforeseen delays do occur, and every effort will be taken to keep your wait as short as possible.

Please arrive 20 minutes before your appointment time.

There is a parking garage underneath the building.

There is complimentary valet parking available on Level G2.

PATIENTS' BILL OF RIGHTS IN A HOSPITAL

As a patient in a hospital in New York State, you have the right, consistent with law, to:

(1) Understand and use these rights. If for any reason you do not understand or you need help, the hospital MUST provide assistance, including an interpreter.

(2) Receive treatment without discrimination as to race, color, religion, sex, gender identity, national origin, disability, sexual orientation, age or source of payment.

(3) Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

(4) Receive emergency care if you need it.

(5) Be informed of the name and position of the doctor who will be in charge of your care in the hospital.

(6) Know the names, positions and functions of any hospital staff involved in your care and refuse their treatment, examination or observation.

(7) Identify a caregiver who will be included in your discharge planning and sharing of post-discharge care information or instruction.

(8) Receive complete information about your diagnosis, treatment and prognosis.

(9) Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.

(10) Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet "Deciding About Health Care — A Guide for Patients and Families."

(11) Refuse treatment and be told what effect this may have on your health.

(12) Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.

(13) Privacy while in the hospital and confidentiality of all information and records regarding your care.

(14) Participate in all decisions about your treatment and discharge from the hospital. The hospital must provide you with a written discharge plan and written description of how you can appeal your discharge.

(15) Review your medical record without charge and, obtain a copy of your medical record for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.

(16) Receive an itemized bill and explanation of all charges.

(17) View a list of the hospital's standard charges for items and services and the health plans the hospital participates with.

(18) Challenge an unexpected bill through the Independent Dispute Resolution process.

(19) Complain without fear of reprisals about the care and services you are receiving and to have the hospital respond to you and if you request it, a written response. If you are not satisfied with the hospital's response, you can complain to the New York State Health Department. The hospital must provide you with the State Health Department telephone number.

(20) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.

(21) Make known your wishes in regard to anatomical gifts. Persons sixteen years of age or older may document their consent to donate their organs, eyes and/or tissues, upon their death, by enrolling in the NYS Donate Life Registry or by documenting their authorization for organ and/or tissue donation in writing in a number of ways (such as a health care proxy, will, donor card, or other signed paper). The health care proxy is available from the hospital.

Public Health Law(PHL)2803 (1)(g)Patient's Rights, 10NYCRR, 405.7,405.7(a)(1),405.7(c)

Northwell Health

REGISTRATION FORM

Instructions: Fill in the blanks and please replace any incorrect or outdated information

Patient Appointment Information

Attending Physician	Scheduled Resource	Appt Date	Appt Time	Encounter #	MGMRN #	Activity Type

Patient Information

Patient Name			Preferred Name	
DOB	Gender	Marital Status	Marital Status Key S – Single D – Divorced M – Married W – Widowed V – Civil Union U – Unknown SEPARATED – Legally Separated PARTNER – Life Partner	
Address		City State Zip		Email Address
Cell Phone	Preferred Language			Preferred Appointment Reminder Method
Home Phone	Ethnicity Ethnicity Key DECL – Declined HIS – Hispanic Origin NHL – Non-Hispanic Origin UNK – Unknown		Race Race Key AIA – Native American Or Alaskan ASN – Asian BAA – African American Or Black DECL – Declined NHP – Native Hawaiian Or Pacific Islander OTH – Other Or Multiracial WHT – White	
Northwell Employee – Yes or No				
Mothers Name – *Optional*			Fathers Name – *Optional*	

Contact Information

Contact Name	Relationship	Contact Type Emergency	Preferred Phone	Alternate Phone
Contact Name	Relationship	Contact Type Next Of Kin	Preferred Phone	Alternate Phone

Guarantor Information

Guarantor Name:	Guarantor DOB	Relationship To Patient
Guarantor Phone	Guarantor Address	City, State, Zip

Physician Information

Referring Physician Name	Referring Physician Phone
Primary Care Physician Name	Primary Care Physician Phone

Insurance Information

Primary Insurance Name	Primary Insurance ID#	Subscriber Name/DOB	Subscriber Relation To Patient
Primary Insurance Address	Primary Insurance Group #		Primary Insurance Phone #
Secondary Insurance Name	Secondary Insurance ID#	Subscriber Name/DOB	Subscriber Relation To Patient
Secondary Insurance Address	Secondary Insurance Group #		Secondary Insurance Phone #

Northwell Health

Authorization for Access to Patient Information - Healthix

PATIENT NAME:	DATE OF BIRTH:	PATIENT IDENTIFICATION NUMBER:
PATIENT ADDRESS:		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow Northwell Health (including their agents) to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Healthix's website at www.healthix.org.

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent even in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

- ☐ 1. **I GIVE CONSENT** for Northwell Health to access ALL of my electronic health information through Healthix to provide health care services (including emergency care).
- ☐ 2. **I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for Northwell Health to access my electronic health information through Healthix.
- ☐ 3. **I DENY CONSENT** for Northwell Health to access my electronic health information through Healthix for any purpose, ***even*** *in a medical emergency.*

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

Patient/Agent/Relative/Guardian* (Signature) _____ Date / Time _____ Print Name _____ Relationship if other than patient _____

Telephonic Interpreter's ID # _____ Date / Time _____
OR

Signature: Interpreter _____ Date / Time _____ Print: Interpreter's Name and Relationship to Patient _____

Witness to signature (Signature) _____ Date / Time _____ Print Witness Name _____

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

Northwell Health

Authorization for Access to Patient Information - Healthix

Details about the information accessed through Healthix and the consent process:

1. **How Your Information May be Used.** Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities. Evaluate and improve the quality of medical care provided to you and all patients.**
2. **What Types of Information about You Are Included.** If you give consent, the Provider Organization(s) listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:

   - Alcohol or drug use problems & diagnoses
   - Birth control and abortion (family planning)
   - Medication and Dosages
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases
   - Diagnostic information
   - Allergies
   - Substance use history summaries
   - Clinical notes
   - Discharge summary
   - Employment Information
   - Living Situation
   - Social Supports
   - Claims Encounter Data
   - Lab Test
   - Trauma history summary
3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by checking Healthix's website at www.healthix.org or by calling 877-695-4749.
4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.
5. **Public Health and Organ Procurement Organization Access.** Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.
6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Provider Organization at: 800-894-3226; or visit Healthix's website: www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.
7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.
8. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice, death or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.
9. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.
10. **Copy of Form.** You are entitled to get a copy of this Consent Form.

Northwell Health Physician Partners

CONSENT TO TREATMENT, ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

Guarantee of Payment

I understand that I am financially responsible for charges not covered by insurance. I agree to pay all amounts for which I am responsible for medical services rendered in accordance with the rates and terms of this practice or as determined by my health plan. Should the account be referred to an attorney for collection, I will pay reasonable attorney's fees and collection expenses.

Patient/Agent/Relative/Guardian* (Signature)	Date	Time	Print Name	Relationship if other than patient
Telephonic Interpreter's ID # OR	Date	Time		
Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient	
Witness to signature (Signature)	Date	Time	Print Witness Name	

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

Northwell Health® Physician Partners

CONTACT CONSENT FORM

Email, Text Messages, and Voicemail

It is important for Northwell Health to be able to communicate with you about your healthcare. If you have provided an email address, cell phone or home phone number, Northwell may use those means of communication to reach out to you about appointment details, office information and limited information about your care. Messages sent through email or SMS text will be limited in the information they contain to protect your privacy. These text messages and emails are not encrypted in transit. To reduce the chance that your information is seen by the wrong recipient, we suggest you enable the highest security measures on your personal devices (passcodes, strong passwords, two step authentication, etc.).

If you DO NOT want Northwell to communicate with you via the email or phone number you provided, please initial below.

☐ DO NOT email me

☐ DO NOT text me

☐ DO NOT leave a voice mail message for me

Northwell will use the cell phone number(s) and/or email address(es) that you provide. It is important for you to keep your contact information with Northwell up to date, and review your email and phone numbers at each visit.

My Care Contacts

☐ Check here if you do not wish for us to speak with anyone but you.

If you would like to authorize Northwell Health to communicate with other individuals about your healthcare, please indicate your communication preferences below.

I give Northwell Health consent to communicate with the following individual(s) about my healthcare (such as appointment details, prescription information, test results).

Name: _____

Relationship: _____

Phone Number: _____

Please see page 2

Northwell Health Physician Partners

CONTACT CONSENT FORM

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

Acknowledgement

By signing below, I understand that Northwell Health has my permission to contact me or my Care Contact(s) identified on this form. I understand that I am responsible for notifying the office staff if there are changes to my designated communication preferences. If I am signing this document on behalf of another person, I acknowledge that I am consenting on behalf of the patient and I will indicate my relationship to the patient where indicated below.

Patient/Agent/Relative/Guardian* (Signature)	Date	Time	Print Name	Relationship if other than patient
Telephonic Interpreter's ID # OR	Date	Time		
Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient	
Witness to signature (Signature)	Date	Time	Print Witness Name	

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

Northwell Health Physician Partners

CONSENT FOR TELEHEALTH SERVICES

Telehealth is the use of electronic information and communication technologies to remotely deliver health care services to patients. Please read this form for information about telehealth services and sign your name below. Your signature tells us that you have read the form and that you agree to receive treatment by telehealth.

General Information

We may use the information you provide to:

- Review your health records, images, and/or test results,
- Have a live two-way interactive audio and video communication with you, and/or
- Review output data from medical devices.

Expected benefits to you of telehealth services may include:

- Improved access to care by allowing you to remain in your home or at a doctor's office while another provider consults on your care.
- More efficient evaluation and care management.
- Obtaining expertise of a specialist, as appropriate.

Possible risks associated with telehealth services may include:

- Delays in evaluation and treatment could occur if the equipment or technology fails or if the telehealth provider decides that the transmitted information is of poor quality. If this is the case, we may need to reschedule the telehealth consult or schedule an in-person appointment with you and your provider.
- Although the electronic communication systems that we use will incorporate security protocols to protect your privacy, security protocols could fail, causing a breach of privacy of personal medical information.

In an Emergency: If you experience an emergency during a telehealth session, your telehealth provider may contact 9-1-1 or your emergency contact.

Acknowledgement and Consent

By checking the box and signing my name below, I acknowledge that I understand and agree with the following:

1. I consent to receive services via telehealth. I have the right to withhold or withdraw my consent to the use of telehealth at any time without affecting my right to future care or treatment.
2. My telehealth provider will determine whether my specific clinical needs are appropriate for care via telehealth. If my provider determines that telehealth is not appropriate for the care I need, I agree to schedule an in-person consult with my provider.
3. My medical information may be shared with others for scheduling and billing purposes and may also be communicated electronically to other providers in connection with my care. These other providers may be located in other areas, including out of state. If I am being treated for substance use disorder, an additional authorization for use of my health information will be provided to me when required by law.
4. I have been informed of all persons who will be present during the telehealth session and been given the opportunity to provide input. If I am a parent or guardian consenting to services for a minor, the patient and I have both had the opportunity to provide input regarding who can be present during a telehealth session.
5. I have the right to have staff available to me during the telehealth session for assistance if my visit is conducted in an office or hospital setting. I understand if my visit is conducted at home, the option for in person staff assistance is not available.

Northwell Health Physician Partners

CONSENT FOR TELEHEALTH SERVICES

6. I will tell my provider where I am located at the time of my telehealth session. I have received location and license information of my telehealth provider as well as information about the staff responsible for my ongoing care.
7. The technology may fail during the telehealth session in which case either I or my provider may terminate the session. If my telehealth session is disrupted or disconnected, my provider will try to reestablish the connection or call me by phone. If we cannot reconnect, a new session will be scheduled. I agree to hold Northwell harmless for delays in evaluation or for information lost due to such technical failures.
8. If I am at home during a telehealth session, I will have access to equipment that supports the telehealth platform and have a private and safe location in which to have the session.
9. I give consent to my provider to record a telehealth session. I will not record the session without my provider's consent and under no circumstance will I record a group therapy session.
10. Alternatives to telehealth services, such as in-person services, are available to me. In choosing to participate in the telehealth services, I understand that additional services, including lab or radiology tests, may require an in-person visit. If I want a different provider, he or she may not be able to provide care via telehealth, which may necessitate an in-person visit that could delay care.
11. I am responsible for all copays and deductibles associated with the telehealth services that I receive. If I do not have insurance or if my insurance does not cover the telehealth services, I understand that I am responsible for the costs of the telehealth session.
12. If I am participating in group therapy services via telehealth, I understand and agree that (a) I must participate from a private location, (b) I will not record the telehealth session, (c) I will not invite or allow others who are not participants in the group to view or listen to the session, (d) I will maintain the confidentiality of group members and not disclose, disseminate, publish, deliver or make available to anyone outside of the group any information that may identify another group member, and (e) I must keep the ID, password and link to the virtual group session confidential. At the end of a group therapy session or if I need to leave a group therapy session early, I agree to fully and quickly logoff of the electronic communications technology platform used to conduct the services. To the extent that I violate the terms of this Section 12 or another participant's privacy in any way, I understand and acknowledge that my participation in the group therapy session may be terminated, and I may no longer be able to participate in the group therapy services via telehealth.

I have read this document carefully. I understand the risks and benefits of the telehealth services and my questions regarding the services, the technology, the costs and the terms of this consent have been answered. I give my consent to participate in the telehealth services under the terms of this Consent for Telehealth Services.

☐ **ACCEPT.** By checking the box for this **"CONSENT FOR TELEHEALTH SERVICES"** I hereby state that I have read, understood, and agree to the terms of this document.

Patient/Agent/Surrogate/Guardian* (Signature):	Date:
Printed name of person signing this form:	Authority to sign on behalf of patient or relationship to patient (if applicable):

*The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or lacks capacity to make medical decisions. In these cases the Agent, Surrogate or Guardian should sign.

Northwell Health

Acknowledgement of Receipt

ADDRESSOGRAPH

I have received a copy of the Provider's Notice of Privacy Practices.

Patient/Agent/Relative/Guardian* (Signature) Date / Time

Print Name Relationship if other than patient

Telephonic Interpreter's ID # Date / Time

OR

Signature: Interpreter Date / Time

Print: Interpreter's Name and Relationship to Patient

Witness to signature (Signature) Date / Time

Print Witness Name

PROVIDER USE ONLY

_____ Patient or patient representative refused to sign/accept Notice of Privacy Practices

_____ Patient unable to sign

Signature Date / Time

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

Northwell Health
Physician Partners

Urogynecology: Female Pelvic Medicine & Reconstructive Surgery

Patient Name: _____ *Date:* _____ *Date of Birth:* _____

New Patient History Form

Age: _____ **Medical Doctor:** _____

Gynecologist: _____ **Referred By:** _____

Allergies: _____ **Pharmacy Name and #** _____

REASON FOR VISIT:

1. _____
2. _____
3. _____
4. _____

PREVIOUS TREATMENTS AND SURGERIES:

1. _____ **Date:** _____
2. _____ **Date:** _____
3. _____ **Date:** _____
4. _____ **Date:** _____

What Medications do you take? (Please include dosage and schedules)

_____ _____ _____

_____ _____ _____

_____ _____ _____

PATIENT MEDICAL HISTORY

Have you ever had/have any of the following: (Place a (√) mark to all that apply).

____Aneurysm	____Depression	____High Blood Pressure	____Other Cancer_____
____Asthma	____Diabetes	____High Cholesterol	____Pneumonia
____Back Injury	____Diverticulitis	____Irritable Bowel Syndrome	____Rheumatic Fever
____Back Problems	____Glaucoma	____Kidney Disease	____Stroke
____Bronchitis	____Head Injury	____Liver Disease	____Thyroid Disorder
____Breast Cancer	____Heart Problems	____Murmur	____Ulcer
____Constipation	____Hernia	____Obesity	

____Other _____

____ **Reviewed and non-contributory to current condition (M.D. ONLY)**

Northwell Health
Physician Partners *Urogynecology: Female Pelvic Medicine & Reconstructive Surgery*

Patient Name: _____ *Date:* _____ *Date of Birth:* _____

FAMILY HISTORY

Does anyone in your family have/had any of the following: (Place a (√) mark to all that apply).

____Asthma	____High Blood Pressure	____Obesity
____Breast Cancer	____High Cholesterol	____Other Cancer _____
____Depression	____Irritable Bowel Syndrome	____Pneumonia
____Diabetes	____Kidney Disease	____Rheumatic Fever
____Glaucoma	____Liver Disease	____Stroke
____Heart Problems	____Murmur	____Thyroid Disorder
		____**Other Systems otherwise Negative (M.D. ONLY)**

SOCIAL HISTORY

Please answer the following questions.

Marital Status: ____Single ____Married ____Divorced ____Widowed

Do you live alone? ____Yes ____No

Do you smoke? ____Yes ____No

Do you use alcohol? ____Yes ____No

If yes, how often? ____Rare ____Socially ____Frequently

Are you currently employed? ____Yes ____No ____Retired

If yes, what type of work? _____

How many cups of caffeine do you drink each day? _____

Have you ever been the victim of domestic violence? _____Yes ____No

Have you ever been the victim of sex abuse? _____Yes ____No

Northwell Health

Physician Partners *Urogynecology: Female Pelvic Medicine & Reconstructive Surgery*

Patient Name: _____ *Date:* _____ *Date of Birth:* _____

OBSTETRICAL AND GYNECOLOGICAL HISTORY

Number of Pregnancies: ____ Number Full Term: _____ Pre Term: _____

Number of Vaginal Deliveries: _____ Largest baby's weight: _____

Are you sexually active at this time? ____Yes ____No

If no, is it because of the current issue(s)? ____Yes ____No

Do you use contraception? ____Yes ____No

If yes, what type? _____

Have you ever had a history of STD's or STI's? ____Yes ____No

If yes, when and what STD or STI's? _____

When was your last Menstrual Period? _____

When was your last Mammogram? _____

Are you taking Estrogen? ____Yes ____No

If yes, since what year? _____

Date of last Pap smear? _____ _____ Normal? ____Yes ____No

Do you have any of the following: (Check (√) all that apply)?

____Bleeding between periods	____Pelvic Pain
____Heavy menstrual periods	____Pain with intercourse
____Pain with periods	____Bleeding after intercourse
____Problem with "falling organs"	____Leak urine with intercourse

Northwell Health

Physician Partners *Urogynecology: Female Pelvic Medicine & Reconstructive Surgery*

Patient Name: _____ *Date:* _____ *Date of Birth:* _____

Please answer *ALL* of the following questions.

Group I

1. Do you lose urine during coughing, sneezing, laughing, or lifting? ____Yes ____No ____Unsure
2. When the urine comes out does it stop when the cough or sneeze is over? ____Yes ____No ____Unsure
3. Do you have good control of urine if you are not coughing, sneezing laughing or straining? ____Yes ____No ____Unsure
4. When the urine leaks, does it stop quickly or continue to drip? ____Stop ____Continue ____Unsure

Group II

1. Do you ever have an uncomfortably strong need to urinate? ____Yes ____No
   If yes, do you leak urine on the way to the toilet? ____Yes ____No
2. Does the sight, sound or feel of running water cause you to lose urine? ____Yes ____No
3. How many times do you urinate during the day? _____
   How many times do you urinate at night, after going to bed? _____
4. Have you wet the bed in the last year? ____Yes ____No
5. Does urine leak out without an apparent cause (no lifting/straining)? ____Yes ____No

Group III

1. Have you ever needed to have your urine removed by a catheter? ____Yes ____No
2. Are you bothered by bulges or pressure in the vagina? ____Yes ____No
3. Do you have difficulty controlling bowel movements? ____Yes ____No
4. What type of protection do you use to avoid urine spillage? _____
   (e.g. Depends, mini-pads, maxi-pads, none)
   Number of pads used during daytime_____ nighttime_____

Patient Signature: _____ *M.D. Signature:* _____