MERCY ST. LUKE'S UROGYNECOLOGY & PELVIC REHABILITATION

Andrew Croak, DO ~ Tracey Begley, WHNP ~ Jill Nichols, WHNP
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6005 MONCLOVA ROAD, SUITE 320 ~ MAUMEE, OH 43537
PHONE: 419 893 7134 ~ FAX: 419 893 6942

WELCOME! Attached is the information packet for you to complete and return, ***BEFORE YOUR APPOINTMENT CAN BE MADE.***

To return the packet, you may:

FAX IT: 419 893 6942

MAIL IT: 6005 Monclova Road, Suite 320 ~ Maumee, Ohio 43537

SCAN & EMAIL: STAFF@NWOUROGYN.COM

STOP IN AND DROP IT OFF IN PERSON

If you do not receive a call within 5 days after sending your packet back, please call the office to confirm it was received.

To speed the process of getting an appointment scheduled, you also have the option to stop in and complete the necessary information and leave it at the front desk.

As a specialist office, it is most helpful to have as much information ***PRIOR*** *to your visit (such as records from other doctors, testing and results, etc.) so that we can be as thorough as possible at your visit.*

If you do plan to bring records with you to the visit, please be advised that your visit could be changed to an information-gathering visit (depending on how much information to review) and a follow-up appointment will be required for evaluation.

PLEASE ARRIVE 20 MINUTES AHEAD OF YOUR APPOINTMENT

*WE UNDERSTAND YOUR TIME IS VALUABLE, AND
WE GREATLY APPRECIATE YOUR COOPERATION
SO YOUR VISIT WILL RUN SMOOTHLY!*

THANK YOU!

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Dear ___________________________,

You have an appointment scheduled with Mercy St. Luke's Urogynecology office on:

____ at __________________________.

PLEASE ARRIVE 20 MINUTES AHEAD OF YOUR APPOINTMENT!

Welcome to our office. We are glad you chose us for all your personal care needs. Our office is located at ***6005 MONCLOVA ROAD, SUITE 320 ~ MAUMEE, OHIO 43537***. *We can be reached at* ***419 893 7134*** *if you have questions*. See directions below to office location.

Please fax, e-mail or mail all completed paperwork ***PRIOR*** *to your visit.*

FAX: 419 893 6942 ***E-MAIL: staff@nwourogyn.com***

It is mandatory that you bring your insurance card, driver's license, and any co-pay at the time of your visit.

We look forward to meeting you, and being able to assist with all of your needs and concerns.

Directions to the Office:

From I-475: Exit expressway at SR-24 Maumee Exit. Go East on SR-24 and follow first stop light. Turn left onto Monclova Road. Follow to Entrance #5 of Mercy St. Luke's campus and turn in to parking lot.

From Downtown Toledo: Use on-ramp for I-75 South to Anthony Wayne Trail. Follow AW Trail to Maumee (Monclova Road). Turn Right on Monclova Road. Follow to Entrance #5 of Mercy St. Luke's campus and turn into parking lot.

From Reynolds Road, West Toledo: Take Reynolds Road (US-20) that passes under the Ohio Turnpike Exit 4A, into Maumee (Conant Street) all the way to SR-24. Turn right on SR-24 and follow to Monclova Road. Turn Right on Monclova Road. Follow to Entrance #5 of Mercy St. Luke's campus and turn into parking lot.

From Ohio Turnpike: Exit at Toledo Reynolds Road Exit. Follow Reynolds Road into Maumee (Conant Street) all the way to SR-24. Turn right on SR-24 and follow to Monclova Road. Turn Right on Monclova Road. Follow to Entrance #5 of Mercy St. Luke's campus and turn into parking lot.

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PATIENT INFORMATION

Name:	SS#:	NCDS#:
Address:	Email:	
City/State/Zip:	DOB:	Sex:
Home Phone:	Marital Status:	
Cell Phone:	Emergency Contact:	
Work Phone:	Emergency Phone:	
Primary Care Physician:	Emergency Relationship:	
Language:		
Race: (circle one) White American Indian Asian Black/African American Unknown Declined		
Ethnicity: (circle one) Non-Hispanic or Latino Hispanic or Latino Declined		

INSURANCE INFORMATION

Primary Ins:	Secondary Ins:
ID #:	ID #:
Group #:	Group #:
Co-Pay:	Co-Pay:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:

Consent for Treatment: I as the patient or legal guardian of, authorize the Insurance Carrier to make checks for medical expenses due me payable to the attending staff or associated practice. I also authorize the release of any information regarding treatment to the Insurance Carrier. I further understand that I am responsible for all medical expenses and agree to pay any expenses not covered by the above Insurance Carriers. I understand that after my primary carrier has paid or rejected payment, I am responsible for the remaining balance and that billing my insurance is done of contractual obligation for participating carriers and is done only as a courtesy for other non-participating carriers.

Health Information Privacy Act (HIPAA) - Check all that apply

Home ☐ OK to leave message w/ detailed information OR ☐ Leave return phone # only
Cell ☐ OK to leave message w/ detailed information OR ☐ Leave return phone # only
Text ☐ Appointment Reminder/General message to call our office
Email ☐ Appointment Reminder/General message to call our office
Home Address: ☐ Ok to mail to my home address

☐ I permit the Practice to discuss my personal health information (PHI) with, and to disclose to, the following individuals:

Name: ____ Phone: ___________________________________
Relationship to Patient: ____
Name: ____ Phone: ___________________________________
Relationship to Patient: ____

I verify that all of the above demographic, insurance, and HIPAA information is true and correct:

____ ________________________
Patient Signature Date

If signed by patient's authorized representative, describe the representative's authority: ________________________________

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Name ____ Age ______ Date of Birth ___________ Today's Date ____________

Who referred you to our office? ______________________________Primary Care Provider ______________________________

What is the reason for your visit today? ____

Menstrual History

Age at first menstrual period _____ First day of your last period _____ If applicable: How many days do your periods last? _____
How many pads/tampons do you typically use in a 24 hours? _____ pads _____ tampons

	Yes	No	N/A
Are your menstrual cycles regular (every 21-35 days)?			
Do you have bleeding or spotting between periods?			
Do you have pain with your periods?			
Do you have pain in your lower abdomen or pelvis other than painful periods?			
If you are menopausal, have you experienced any further vaginal bleeding?			

In order to have complete medical diagnoses and treatment, please answer the following:

Gender Identity: _____Male _____ Female _____Transgender: _____ MTF _____ FTM
If applicable, preference of Gender Pronoun to be used: ____

Sexual History

	Yes	No	N/A
Are you sexually active? (If yes, please circle: with a man / woman / both)			
Do you have pain with intercourse?			
Do you have bleeding during or after intercourse?			
Are you satisfied with your current sexual health?			
Are you using birth control? If yes, what method? ___________________________			
Have you ever had a sexually transmitted infection? If yes, please explain: _________ ____			

Pregnancy History

Total number of pregnancies: _____ Vaginal Deliveries: _____ C-Sections: _____ Miscarriages: _____
Ectopic pregnancies: _____ Abortions: _____

Have you recently had any of the following symptoms (within the last month)?

	Yes	No		Yes	No		Yes	No
Vaginal discharge			Burning or pain with urination			Pressure or bulge at the opening of the vagina		
Vulvar itching or irritation			Leakage of urine					
Breast pain			Frequent urination			Incontinence of stool		
Breast lump/mass			Difficulty emptying your bladder			Blood in your stool		
Hot flashes and/or night sweats			Urinary tract infections			Significant/chronic diarrhea		
Weight gain/loss of 10 lbs			Chronic coughing			Significant/chronic constipation		

Patient Name ______________________________________

Personal Medical History (check all that apply)

O Breast cancer	O Tension headaches	O Thyroid disease	O Jaundice/Hepatitis
O Ovarian cancer	O Migraine headaches	O Parkinson's disease	O HIV/AIDS
O Uterine cancer	O Seizures/Epilepsy	O Osteoporosis/osteopenia	O Birth defects
O Colon cancer	O Multiple sclerosis	O Bone fracture	O Exposure to DES
O Other cancer: ____________	O Anxiety	O Vitamin D deficiency	O Digestive problems
O Abnormal pap test	O Depression	O Arthritis	O Breast problems
O Diabetes	O Heart attack	O Joint replacement	O Colon problems
O High blood pressure	O Stroke	O Lung disease _____________	O Bladder/kidney disease
O High cholesterol	O Blood clots: _____________	O Skin problems ____________	O Urinary infections
O Heart disease	O Heart valve problem	O Anemia	O Glaucoma

Please provide details for any conditions selected above or list other diagnoses not above: __________________________________

____

____

Do you have to take antibiotics before dental work or other procedures? O Yes O No If yes, reason: __________

____

Drug/Food/Other Allergies (Please give reaction, i.e. hives)

O **N/A** (please check box if this does not apply)

____

____

Surgical History

Date	Procedure	Reason for Surgery
O **N/A** (please check box if this does not apply)		

Medications

Please list all prescription and over-the-counter medications, vitamins, and herbal supplements:

O **N/A** (please check box if this does not apply)

Name of medication	Dose	How often taken	Name of medication	Dose	How often taken

Patient Name ____

Pharmacy Information

	Name	Street Address	City, State Zip	Phone
LOCAL				
MAIL ORDER				

Family History

	Father	Mother	Brothers	Sisters	Sons	Daughters
How Many?	1	1				
Deceased? Yes/no						
Diagnosis:						
Diabetes						
Cardiac						
Breast Cancer						
Cervical Cancer						
Uterine Cancer						
Colon Cancer						
Bleeding Disorders						
Osteoporosis						

Social History

Marital Status: O Single O Married O Divorced O Widowed Occupation: ____________________________ O Retired

How many servings of caffeine do you consume per day? ________ Type? ____

Do you currently smoke? O Yes O No # Cigarettes/Day: ______ How many years? ______

If no, did you ever smoke? O Yes O No How long ago did you quit? ______________

Do you consume alcohol? O Yes O No How many alcoholic beverages/week? ______

Do you use illicit drugs? O Yes O No List: ____

In an average week, how many minutes of vigorous physical activity do you get? _____________________

Do you consume foods/drinks containing calcium on a daily basis? (i.e., milk, yogurt, cheese, etc.) O Yes O No

Please list any religious or cultural needs regarding your care: ____

Preventative History

Last Pap Smear/Pelvic Exam: __________________ Facility: ____

Have you ever had an abnormal pap smear? O Yes O No Treatment if applicable: ______________________________

Last Mammogram: ___________________ Facility: ____

Have you ever had an abnormal mammogram? O Yes O No Treatment if applicable: ______________________________

Last Bone Density Test (DEXA scan): _________________ Facility: ____

Last Colonoscopy/sigmoidoscopy: ___________________ Facility: ____

Are you up-to-date on your immunizations? O Yes O No

Dates of Last: Flu: __________ Tdap: __________ Pneumonia: __________ Herpes Zoster (Shingles): __________

Gardasil (HPV): __________ Covid-19: __________

AUA SYMPTOM SCORE (AUASS)

Patient Name: ________________________________ Today's Date: ________________________

Directions: Circle only one number on each line.

	Not At All	Less Than 1 Time in 5	Less Than Half the Time	About Half the Time	More Than Half the Time	Almost Always
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you found you stopped and started again several times when you urinated	0	1	2	3	4	5
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
During the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	NONE	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 or More Times**
Over the past month or so, how many times per night did you get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Add the score for each number above and write the total in the space to the right: TOTAL: ____________

SYMPTOM SCORE: 1-7 (Mild) 8-19 (Moderate) 20-35 (Severe)

QUALITY OF LIFE (QOL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6