OhioHealth

OhioHealth
Urogynecology Physicians
Formerly Riverside Center
for Female Continence and
Reconstructive Pelvic Surgery

OhioHealth Riverside
Methodist Hospital
3555 Olentangy River Road
South Medical Building, Suite 4050
Columbus, Ohio 43214
(614) 566.2727 fax | 566.2712

RiversideUroGyn.com

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Female Pelvic Medicine and
Reconstructive Surgery

Dear: _____

Your physician has contacted our office with a referral for you to see

_____. You are scheduled in our Urogynecology office on:

Date: _____

Appointment time :_____

*Please arrive 30 minutes early

***If you do not arrive within 15 minutes of your appointment time we reserve the right to reschedule your appointment.**

If circumstances arise that prevent you from keeping this appointment, please call our office at 614-566-2727 to reschedule your appointment.

Enclosed, please find a set of "New Patient" forms and a map to our office. Please complete these forms **before** you come to your appointment. Be sure to complete every page of your new patient packet and bring these with you to your appointment. **Do not mail** your new patient packet before your appointment.

On the day of your appointment, please bring the following items:

1. **Completed set of new patient forms.**
2. **Current insurance card and/or cards.**
3. **A complete list of all of the medications you are currently taking.**
4. **Bladder diary**
5. **Photo I.D.**
6. **Your copay if your insurance requires one.**

We look forward to seeing you. If you have any questions or concerns, please contact our office at 614-566-2727.

OhioHealth Urogynecology Physicians
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****Please be sure to notify our office of your insurance changes prior to your visit. ****

First Name: _____ Middle_____ Last_____ AKA_____ DOB_____

Address: _____ City: _____ State: _____ Zip: _____

Home #:_____ Cell #:_____ Work # _____

Email address_____ SS # _____

**Preferred Method of Contact: ❑ Home ❑ Cell ❑ Work ❑ Email

**May we leave messages about appointments and results? (Check all that apply) ❑ No ❑ Yes

❑ Home ❑ Cell ❑ Work

Gender: ❑ M ❑ F Marital Status: _____ Spouse's Name: _____

Employer: _____ Occupation: _____

Race/Ethnicity: _____ Preferred Language: _____

Family Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Pharmacy: _____ Phone #: _____

Minor Patients: Child lives with: _____ Contact #: _____

Mother/Guardian:_____ Contact #: _____

Father/Guardian: _____ Contact #: _____

Responsible Party, if different than above

Name: _____ Relationship to Patient: _____

Primary Insurance: _____ Employer: _____

Policy Holder: _____ DOB:_____Relationship: _____

ID/ SS#: _____ Group #: _____

Secondary Insurance: _____ Employer: _____

Policy Holder: _____ DOB:_____Relationship: _____

ID/SS#: _____ Group #: _____

Is today's visit related to an accident? ❑ No ❑ Yes Date of Accident _____

PATIENT IDENTIFICATION LABEL

OhioHealth

REGISTRATION FORM

If work related, please complete the following questions:

Employer: _____ Address: _____ Phone #: _____

Date of Injury: _____ Claim #: _____

Allowed Diagnosis: _____

MCO: _____ Phone#: _____

Case Manager: _____ Phone#: _____

Have you filed paperwork with your employer? ❑ No ❑ Yes

Do you have an attorney? ❑ No ❑ Yes

Name: _____ Phone#: _____

Many of our patients during their recovery may stay with family members, friends or at a rehabilitation or nursing facility. Please provide our office staff with information as to where you are currently staying so we are able to contact you.

I am staying with a: ❑ Relative ❑ Friend ❑ Rehabilitation Center ❑ Skilled Nursing Facility

Name of Relative/Friend/ Facility: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Do you have a Health Care Power of Attorney? ❑ No ❑ Yes

Name of POA: _____ Contact #: _____

(If yes, please provide a copy of the POA documents)

With whom may we contact in case of an emergency or leave medical information with? Indicate whether or not we may discuss medical information pertinent to your treatment with this person.

Name: _____ Relationship: _____ DOB _____ Phone #: _____ ❑ No ❑ Yes

Name: _____ Relationship: _____ DOB _____ Phone #: _____ ❑ No ❑ Yes

Name: _____ Relationship: _____ DOB _____ Phone #: _____ ❑ No ❑ Yes

Patient/Guardian Signature: _____ Date: _____ Time: _____

OhioHealth Urogynecology Physicians

Patient: _____

Date of Birth: _____

Pharmacy and Phone #:_____

_____

Allergies: _____

Reactions:

_____

_____

_____

Diabetic: *No _____* *Yes _____*

<u>Current Medications</u>

Date *Name of Medication* *Dosage*

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

OhioHealth Urogynecology Physicians

Patient's Name: _____

Due to the Privacy Law (HIPPA**),** you must **list the name of each person** (other than yourself/Primary care and/or referring physician) that you give permission to have access regarding your patient information, diagnosis, treatment, and plan of care.

Appointment Scheduling Information: Name:_____

Billing Information: Name:_____

Lab and Testing Results: Name:_____

Prescriptions /Medication Information: Name:_____

Authorization to Leave Messages

I give my authorization to leave messages regarding my medical condition on my home answering machine. This authorization will be in effect until I have given written notice.

_____ Date:_____

Authorization to Contact at Employment

I give my authorization to be contacted while at my place of employment. This authorization will be in effect until I have given written notice to the office to the contrary.

_____ Date: _____

OhioHealth Urogynecology Physicians
New Patient History

Name:_____ Date of Birth:____/____/____

Primary Care Physician:_____

OB/GYN Physician:_____

Who recommended evaluation at this practice?_____

Reason for consultation:_____

_____

Medical History:

Do you have or have you ever had any of the following? Check yes or no.

Heart disease	__no __yes	Diabetes	__no __yes
Heart attack	__no __yes	Asthma	__no __yes
High Blood Pressure	__no __yes	Emphysema/COPD	__no __yes
Stroke or TIA	__no __yes	Liver Disease	__no __yes
Blood clots/DVT	__no __yes	Thyroid Disease	__no __yes
Kidney Stones	__no __yes	Kidney Disease	__no __yes
Depression	__no __yes	Irritable Bowel Syndrome	__no __yes
		Glaucoma	__no __yes
Cancer:	__no __yes	If yes: type_____	
Other	_____		

_____

Surgical History:

Year	Type of Surgery	Surgeon	Hospital/City
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you or anyone in your family had problems with anesthesia? ___no ___yes

If so describe your reaction:_____

Previous Treatment for Prolapse or Incontinence:

Previous Medications:_____

Trial of a Pessary:_____

Physical Therapy:_____

Diagnostic Testing:_____

OB.GYN History:

Number of Pregnancies_____ # of Miscarriages:_____ # of Live Births_____
# of Vaginal Deliveries _____ # of Cesarean Section Deliveries _____

Largest Baby Weight:_____ Vacuum ____yes ____ no
Forceps ____yes ____no
Episiotomy ____yes ____no
Perineal Laceration ____yes ___no grade___

Last Pap Smear: When? _____ Normal: ____yes ____no
History abnormal Pap: ____yes ____ no

Last Mammogram: When? _____ Normal: ___yes ___no

Last Colonoscopy: When? _____ Normal: ___yes ___ no

Currently sexually active? ____yes ____no
Current # partners: _____
____Male ___ Female ___ Both
History of Sexually transmitted diseases: ___yes ___no _____
Pain with intercourse: ___no ___yes
Contraception: _____

Allergies:

Are you allergic to latex? ___no ___yes (If yes, what is your reaction?)
_____

Are you allergic to IVP dye? ___no ___yes (If yes, what is your reaction?)
_____

Are you allergic to any medications? ___ no ___ yes (If yes, list the name and reaction)
_____

_____

_____

Family History:

Has anyone in your family been diagnosed with any of the following?
If yes, list their relationship to you (sister, son, maternal aunt, paternal grandfather, etc)

High blood pressure ___no ___yes:_____
Stroke or TIA ___no ___yes:_____
Heart disease/heart attack ___no ___yes:_____
Blood Clots ___no ___yes:_____
Diabetes ___no ___yes:_____
Breast Cancer ___no ___yes:_____
Ovarian Cancer ___no ___yes:_____
Uterine/Endometrial Cancer ___no ___yes:_____
Colorectal Cancer ___no ___yes:_____
Bladder or Kidney Cancer ___no ___yes:_____
Urinary incontinence ___no ___yes:_____
Pelvic Organ Prolapse ___no ___yes:_____

Social History:

Do you:
Smoke cigarettes ___no ___yes (how many packs per day?)_____
How many years?_____

Drink Alcohol ___no ___yes (how many drinks per week?)_____

Use Drugs ___no ___yes (what type and how often?)_____
_____

Do you work outside of the home? __no __yes.
(If yes, what is your job?)_____
Are you married/involved in a committed relationship? __no __yes
Are you sexually active? __no __yes
Is your partner: ____male, ____female, ____both.
Have you been subjected to sexual abuse as a child or adult? ___no ___yes
Have you been subjected to physical abuse as a child or adult? ___no ___yes
What is your normal level of physical activity?

____I am very active and exercise regularly. (Yard work, lifting, aerobics, etc)
____I am active but do not actively exercise (housework and regular walking)
____I am a little active. (light housework, occasional walking)
____I am not active (sit most of the day)

Review of Systems:

Do you currently have problems with: (check/circle all that apply)

1. Fatigue, weight gain or loss, night sweats, fevers? ___no___yes
2. Vision, hearing, sense of smell, difficulty swallowing? ___no___yes
3. Chest pain, palpitations, fainting? ___no___yes
4. Shortness of breath, chronic cough, wheezing? ___no___yes
5. Nausea, vomiting, diarrhea, constipation, bloating? ___no___yes
6. Abdominal pain, indigestion, blood in stool, change in stool? ___no___yes
7. Muscle pain, joint pain, muscle weakness, leg swelling? ___no___yes
8. Skin rashes, skin lesions, easy bruising or bleeding? ___no___yes
9. Seizures, fainting, numbness, tremors, headaches? ___no___yes
10. Depression, anxiety? ___no___yes
11. Excessive thirst, feeling too hot/ too cold? ___no___yes
12. Allergies, swollen glands, immune diseases? ___no___yes

Please answer the following questions:

1. Were you treated for more than two urinary tract infections (bladder infections) in the last year? ___no ___yes
2. Do you have difficulty emptying your bladder? ___no ___yes
3. Do you have pain when you urinate? ___no ___yes
4. How many times do you get up each night to empty your bladder?
   _____1 to 2 times _____3 to 4 times _____5 times or more
   How many times during the day do you empty your bladder? _____.
5. How often do you have bowel movements?
   ____daily ____every other day ____once or twice/week ___less than once/week
6. Do you leak stool from your rectum? ____no ____yes
   If yes, is the stool ____liquid ____loose ____soft ____formed

Please answer the following questions if you experience urinary incontinence:

1. Do you usually have an urge to urinate before you leak urine? ___no ___yes
2. Does the sound or feel of running water make you leak urine? ___no ___yes
3. Do you leak urine when you approach your home after being out? ___no ___yes
4. When you have an urge to urinate, can you hold your urine until you get to the bathroom? ___always ___most of the time ___sometimes ___never
5. Do you leak urine when you cough, sneeze, laugh, or exercise? ___no ___yes
6. Do you wet the bed when you are completely asleep? ___no ___yes
7. Do you feel like you leak urine constantly? ___no ___yes
8. Do you wear pads to protect your clothing from leakage? ___no ___yes
   If yes, what kind? ___panti liner___thin pad ___thick pad ___protective undergarment
9. Do you feel like you leak urine during intercourse? ___no ___ yes

Please circle the best answer for each question:

Do you experience, and if so, how much are you bothered by: **Score:_____**

	Not at all	Slightly		Moderately	Greatly
Frequent Urination?	0	1	2	3	
Urine leakage related to the feeling of urgency? (sudden desire to urinate)	0	1	2	3	
Urine leakage related to physical activity, coughing, sneezing?	0	1	2	3	
Small amounts of urine leakage (drops)?	0	1	2	3	
Difficulty emptying your bladder?	0	1	2	3	
Pain or discomfort in the lower abdominal or genital area?	0	1	2	3	

Has Urine Leakage Affected Your: **Score:_____**

	Not at all	Slightly		Moderately	Greatly
Ability to do household chores (cooking, housecleaning, laundry)?	0	1	2	3	
Physical recreation such as walking, swimming, or exercise?	0	1	2	3	
Entertainment activities (movies, concerts, etc)?	0	1	2	3	
Ability to travel by car or bus more than 30 minutes from home?	0	1	2	3	
Participation in social activities outside your home?	0	1	2	3	
Emotional health (nervousness, depression, etc)?	0	1	2	3	
Feeling frustrated?	0	1	2	3	

Medication Form

On the next page please list all medications you are currently taking including any over-the-counter medications, vitamins, herbal supplements and home remedies. Include the dose and when you take it. If you need more room please make a list on a separate sheet of paper.

_____ _____

Patient Signature Date

Reviewed with the patient on: _____

Signed: _____

OhioHealth Urogynecolgy Physicians

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Courtney Kuharik, PA-C

BLADDER DIARY

This Bladder Diary is a record of your voiding and leakages of urine.
Please complete this diary and bring it with you to your new patient office visit.

INSTRUCTIONS:

- **Choose a 72 hour period (3 days) when you can record every voiding episode.**
- **Record on the diary each time you void on the toilet and each time you have leakage of urine.**
- **Begin the diary with your first morning void.**

See example and explanations below:

1 Time	2 Amount Voided	3 Amount Leaked	4 Activity	5 Urge Present?	6 Amount/ type of fluid intake
6:30 AM	Normal				
7:30 AM					Coffee-10 ounces
8:00 AM		2	Washing dishes	yes	

1. **Record the time of all voids, leakage, and intake of fluid.**
2. **Estimate the amount that you voided; for example- drops, small, normal, or large.**
3. **Estimate the amount of all leakages according to the following scale;**
    a. **1= damp, few drops only**
    b. **2= wet underwear or pad**
    c. **3= soaked underwear or pad**
4. **Describe the activity you were performing at t he time of all leakages. If you were not actively doing anything,, record if you were sitting, standing or lying down.**
4. **If you have the urge to urinate when the urine leakage occurs, write yes. If you felt no urge when the leakage occurred, write no.**
5. **Record the amount and type of all fluid intake in ounces or cc's (1cup=8 oz.=240cc)**

Notes:

- **If you are recording a void, the column will be blank; if it is a leak, the amount voided will be blank.**
- **If you have any questions about this diary, please feel free to contact our office.**

Our phone number is 614-566-2727.

Voiding Dairy

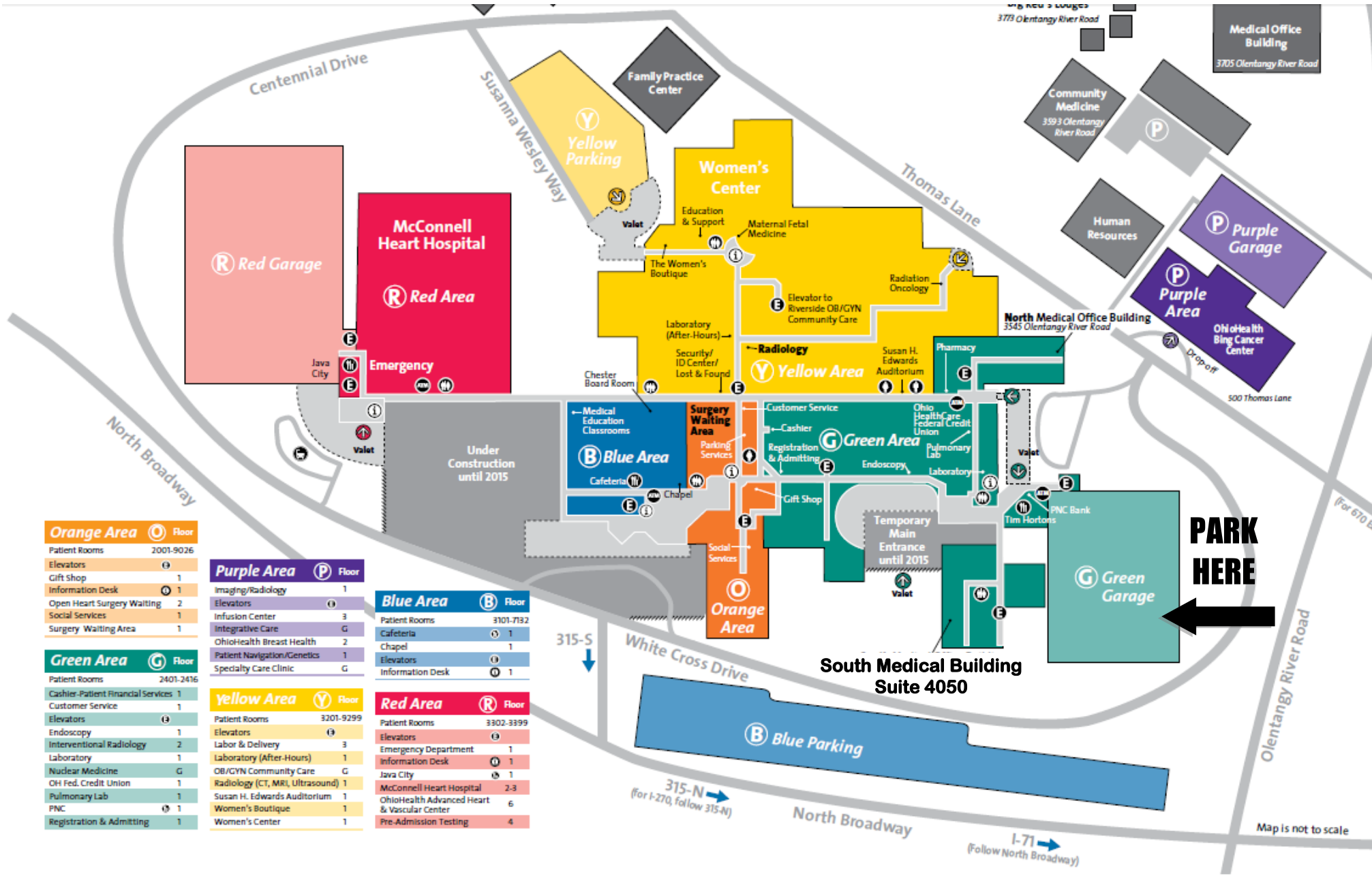
1 Time	2 Amount Voided	3 Leak Amount	4 Activity	5 Urge Present?	6 amount/type of fluid intake

Voiding Diary

1 Time	2 Amount Voided	3 Leak Amount	4 Activity	5 Urge Present?	6 amount/type of fluid intake

1 Time	2 Amount Voided	3 Leak Amount	4 Activity	5 Urge Present?	6 amount/type of fluid intake

When you arrive at Riverside Methodist Hospital, park in the **green parking garage**.
When you enter the building from the garage, you will be in the south medical office building.
There is a hallway between Tim Horton's and the Information Desk.
Walk down the slanted hallway to the elevators located at the bottom.
Take the elevator to the **fourth (4th) floor, suite 4050**



Orange Area	Floor
Patient Rooms	2001-9026
Elevators	
Gift Shop	1
Information Desk	1
Open Heart Surgery Waiting	2
Social Services	1
Surgery Waiting Area	1

Green Area	Floor
Patient Rooms	2401-2416
Cashier-Patient Financial Services	1
Customer Service	1
Elevators	
Endoscopy	1
Interventional Radiology	2
Laboratory	1
Nuclear Medicine	G
OH Fed. Credit Union	1
Pulmonary Lab	1
PNC	1
Registration & Admitting	1

Purple Area	Floor
Imaging/Radiology	1
Elevators	
Infusion Center	3
Integrative Care	G
OhioHealth Breast Health	2
Patient Navigation/Genetics	1
Specialty Care Clinic	G

Yellow Area	Floor
Patient Rooms	3201-9299
Elevators	
Labor & Delivery	3
Laboratory (After-Hours)	1
OB/GYN Community Care	G
Radiology (CT, MRI, Ultrasound)	1
Susan H. Edwards Auditorium	1
Women's Boutique	1
Women's Center	1

Blue Area	Floor
Patient Rooms	3101-7132
Cafeteria	1
Chapel	1
Elevators	
Information Desk	1

Red Area	Floor
Patient Rooms	3302-3399
Elevators	
Emergency Department	1
Information Desk	1
Java City	1
McConnell Heart Hospital	2-3
OhioHealth Advanced Heart & Vascular Center	6
Pre-Admission Testing	4