***Board Certified Urogynecologists:***

**Barbara R. Henley, MD**

**Jennifer L. Lanzer, MD**

***Urogynecology Physician Assistant:***

**Melania Velasquez, PA-C**

Female Pelvic Medicine & Reconstructive Surgery

Appointments: (706) 446-5901 ⦁ Nursing (706) 446-5906 ⦁Fax (706) 651-7400

2834 Hillcreek Drive, Augusta, GA 30909

[](http://www.augustahealth.org/)

We are looking forward to your upcoming visit with Urogynecology (Female Pelvic Medicine & Reconstructive Surgery) at Augusta University Women’s Health at Hillcreek.

**In order to facilitate your visit, please complete the following forms before your scheduled appointment. These forms will be collected when you check-in for your appointment.**

If you have any questions prior to your visit, please contact our office or visit our website at **www.augustahealth.org/urogyn**.

**Appointment with**

**Barbara R. Henley, MD Jennifer Lanzer, MD**

**Melania Velasquez, PA-C**

**Date: \_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Last Name First Name Birthdate Age

Preferred Name

Do any of these describe you?  Intersex  Transgender  Gender fluid

**Referring Physician:** **Primary Care Physician:**

Name Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip City State Zip \_\_\_\_\_\_\_

**Pharmacy**

Phone No.

Address

City State Zip

**Today’s Visit:**

What is the main reason you came to the office today?

When did it start?

What treatments have you had so far for this health issue?

Kegel exercises? Medications? If so, what medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pessary? Vaginal estrogen cream? Pelvic floor physical therapy?

Other?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**URINARY INCONTINENCE**

|  |  |
| --- | --- |
| Do you experience leakage of urine? YES / NO  If yes, how long? months years | Do you leak urine when you cough, sneeze, or laugh?  YES / NO |
| After you urinate, do you have dribbling? YES / NO | Do you leak urine with urgency or on the way to the  bathroom? YES / NO |
| **Please check if you leak urine during the following times:**   Walking  Running  Urgency  Changing from sitting to standing  Lying down   Exercise  Straining or lifting  With Intercourse  Minimal activity | |
| Do you use a pad for urine leakage? YES / NO  If yes, how many a day? | How long can you postpone emptying your bladder when  you have the urge to urinate? minutes or \_hours |
| Do you ever wet the bed while sleeping? YES / NO | What amount of leakage do you experience?   Drops  More than drops Flood   Leak Continually |

**UROLOGIC HISTORY**

|  |  |
| --- | --- |
| Number of urinary tract infections in the last year? | Any blood in the urine? YES / NO  If yes, when? |
| Any kidney infections (pyelonephritis)? YES / NO | Do you find it hard to begin urinating? YES / NO |
| Any history of kidney stones? YES / NO  If yes, then explain: | Did you have urinary problems in childhood?  YES / NO |
| After emptying your bladder, do you feel like you have emptied completely? YES / NO | Have you ever been catheterized in order to pass urine?  YES / NO |
| How many times do you urinate during the day? | How many times do you urinate at night after you go to sleep?\_\_\_\_\_\_  What time do you stop drinking fluids at night? \_\_\_\_\_ pm |

**BOWEL SYMPTOMS**

Diarrhea YES / NO Constipation YES / NO Laxative Use YES / NO Do you have “accidents” with stool or gas?:

fecal soiling YES / NO liquid stools YES / NO

formed stools YES / NO

flatus gas YES / NO

If yes, how often do you have “accidents”?\_\_\_\_\_\_\_

**PROLAPSE**

Do you strain with a bowel movement? YES / NO

Do you experience pressure and/or heaviness in the vagina? YES / NO

Do you feel a bulge in the vagina? YES / NO

Do you see a bulge in the vagina? YES / NO

Do you push with a finger in the vagina to assist with a bowel movement? YES / NO

How often do you have a bowel movement? \_\_\_\_\_\_\_\_

Please list any allergies (food, medications, etc.) and your reaction to them:

Allergy Reaction

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list or attach a list of your current medications, dose, and how often you take them *(this includes birth control and hormone replacement meds).* Also, please include any vitamins or herbal supplements you are taking as well:

Medication Dose How often

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Fluid Intake:**

Approximately how many ounces of fluid do you drink per day (a typical glass/cup is 8 oz)? \_\_\_\_\_\_\_\_\_\_oz

What do you mostly drink? Water Tea Coffee Soda/soft drinks Wine/alcohol Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:**

Please list any and all current medical conditions you may have:

1. 2.

3. 4.

5. 6.

7. 8.

**Surgical History:**

Please list any past surgeries and date:

1. 2.

3. 4.

5. 6.

Please indicate the most recent date/result for the following procedures. If a procedure does not apply to you, select ‘No’.

|  |  |  |  |
| --- | --- | --- | --- |
| Procedure |  | Date | Result |
| Pap Smear |  Yes  No |  |  |
| Colonoscopy |  Yes  No |  |  |

**Past Obstetrical History:**

How many times have you been pregnant? \_\_\_\_\_\_\_\_

**(Please skip if no pregnancies)**

Of these pregnancies, how many were…**along w/ year(s)**

vaginal deliveries \_\_\_\_\_\_\_\_ Year(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

cesarean deliveries \_\_\_\_\_\_\_\_\_\_\_\_ Year(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

full term deliveries \_\_\_\_\_\_\_\_\_\_\_\_ Year(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

preterm deliveries \_\_\_\_\_\_\_\_\_\_\_\_ Year(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

miscarriages or abortions \_\_\_\_\_\_\_\_\_\_\_\_ Year(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

forceps or vacuum \_\_\_\_\_\_\_\_\_\_\_\_ Year(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight of largest baby:

Episiotomy: YES / NO

Large tear: YES / NO

**Past Gynecological History:**

What was the first day of your last menstrual period? Are you sexually active?  Yes  No

Do you experience pain with intercourse?  Yes  No

**Social History:**

Are you?  Single  Married  Divorced  Widowed

Who do you live with?

Do you work now?  Yes  No

What is your current or most recent job?

Do you exercise?  Yes  No

Describe your current exercise routine. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke?  Yes, current smoker  No, former smoker  No, never smoked

If yes (or former), how many cigarretes per day?  5  10  20 (one pack)  More than 20

Would you like help to quit smoking?  Yes  No

How often do you drink alcohol?  Daily  Weekly  Occasionally  Never

Do you use any other drugs?  Yes  No Please list

**Family History:**

Have any of your relatives had any of the following illnesses?

Diabetes  Yes  No Who?

Stroke  Yes  No Who?

Asthma  Yes  No Who?

Migraine headaches  Yes  No Who?

Hypertension  Yes  No Who?

Heart Disease  Yes  No Who?

Kidney problems  Yes  No Who?

Mental disease  Yes  No Who?

Cancer  Yes  No Who and what type?

**Please indicate whether each of the following is currently a concern for you.**

**General Skin**

 Yes  No Excessive fatigue  Yes  No Rashes

 Yes  No Weight loss  Yes  No Recurrent sores

 Yes  No Excessive thirst  Yes  No Moles that have changed in color or size

 Yes  No Feeling abnormally hot or cold  Yes  No Swollen glands

 Yes  No Lumps or swelling  Yes  No Itching

**Eye, Ear, Nose & Mouth Heart**

 Yes  No Hearing difficulty  Yes  No Chest pain

 Yes  No Ringing in the ear  Yes  No Heart palpitations *(irregular heart beat)*

 Yes  No Change in vision  Yes  No Discomfort in chest with exercise or walking

 Yes  No Change in voice  Yes  No Difficulty breathing

 Yes  No Difficulty swallowing  Yes  No High blood pressure

 Yes  No Anemia

**Breasts Nervous System**

 Yes  No Lumps  Yes  No Frequent or severe headaches

 Yes  No Tenderness  Yes  No Dizziness

 Yes  No Swelling  Yes  No Fainting *(fell out)*

 Yes  No Nipple discharge  Yes  No Recurrent numbness or tingling of hands / feet

 Yes  No Skin changes / rash  Yes  No Mood swings, irritability

 Yes  No Depression or anxiety

**Lungs Urinary**

 Yes  No Shortness of breath  Yes  No Pain when urinating

 Yes  No Cough  Yes  No Excessive urinating at night

 Yes  No Wheezing  Yes  No Bladder infections

 Yes  No Coughing up blood  Yes  No Leakage of urine

 Yes  No Kidney stones

**Gastrointestinal Gynecological**

 Yes  No Poor appetite  Yes  No Heavy bleeding

 Yes  No Frequent nausea and / or vomiting  Yes  No Bleeding between periods

 Yes  No Heartburn  Yes  No Irregular bleeding

 Yes  No Black, tarry stool  Yes  No Severe cramps with period

 Yes  No Constipation  Yes  No Pelvic pain

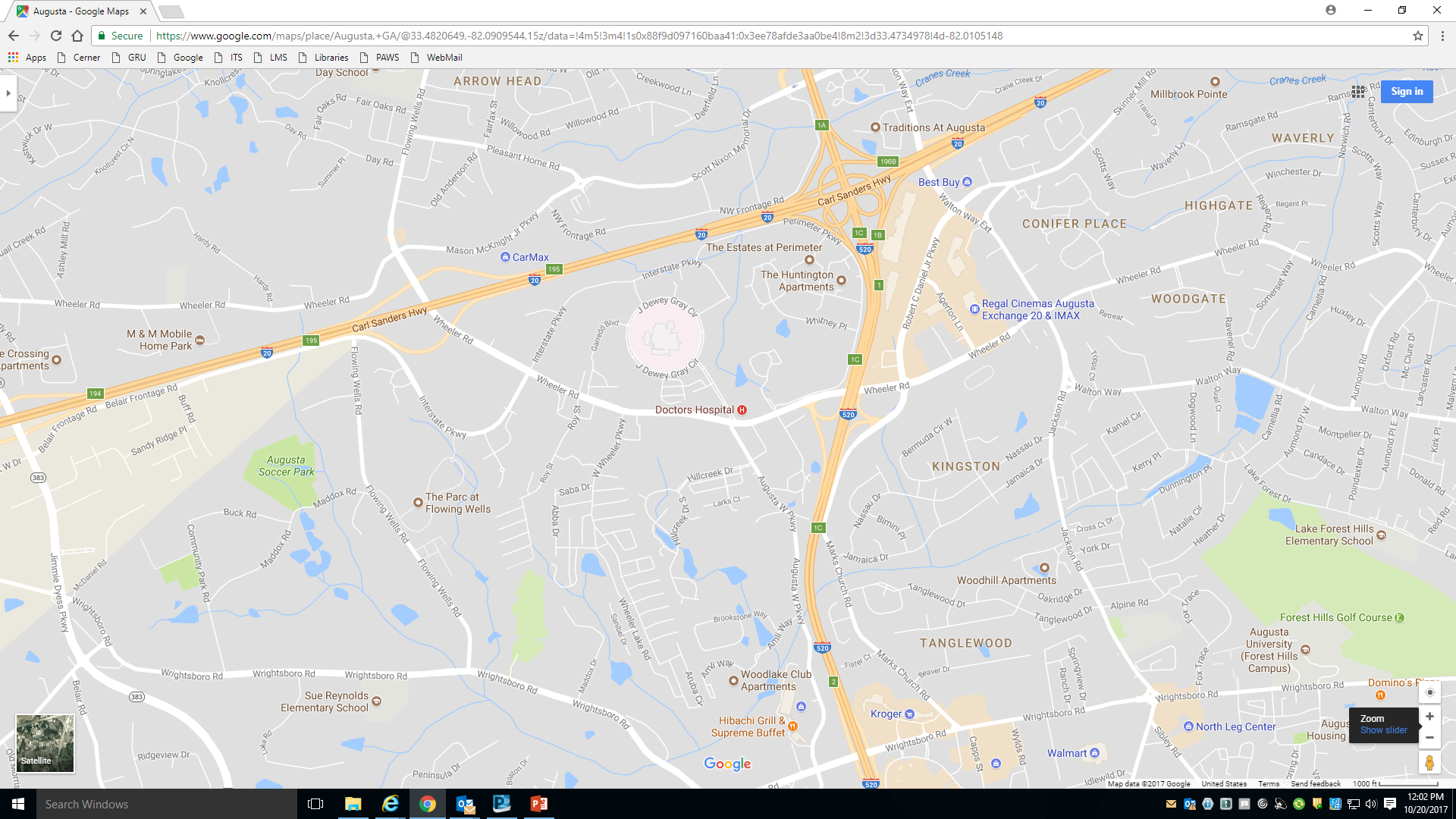
 Yes  No Diarrhea  Yes  No Sores or ulcers

 Yes  No Blood in stool  Yes  No Vaginal discharge

 Yes  No Foul smelling odor

 Yes  No Pain after sex

 Yes  No Bleeding after sex

 2834 Hillcreek Drive Augusta, GA 30909

* From Wheeler Rd. Turn onto Augusta West Parkway (the opposite way of Doctors Hospital)
* Take your **First Right** onto Hillcreek Drive (Just before the Regions Bank)
* Once on Hillcreek Drive make the **Third Left** into the office complex (the last one before you see houses)
* Turn left and we are the first office on the Right. A brick exterior with 3 arched windows.

We look forward to seeing you at your appointment!