CENTER FOR
PELVIC HEALTH AND WELLNESS

Welcome to the Center for Pelvic Health and Wellness!

We are dedicated to your total pelvic health and lifelong wellness.

To individualize your care and create a comprehensive treatment and wellness plan for you, we ask you to take time to **FILL OUT our PATIENT FORMS PRIOR to** and **bring to your first appointment**.

New patient forms are available on our website www.pelvichealthwellness.com and click on forms. You **may also fax them back to us at 949-364-2829 or email them** to info@pelvichealthwellness.com. Please make sure to bring your **insurance card and photo ID** with you on your initial appointment.

Please arrive 30 minutes early for your office visit, to allow us to confirm that we have everything we need to get you on your path towards pelvic health and wellness.

New Patient Visit
Your initial visit is comprised of a complete and thorough review and evaluation of your health history and a focused physical exam. Your provider may recommend additional tests before finalizing your comprehensive and integrative plan, including blood work, bladder testing, imaging, and records from past evaluations.
If you have copies of past evaluations and treatments, please bring with you to your visit.

Lab Tests, Imaging, or Mammograms
Your provider will provide you with necessary lab or imaging requisition forms. Please take these forms to the contracted facility with your insurance plan. If one has a high insurance deductible, paying cash for services may be more cost effective.

The Center for Pelvic Health and Wellness also has a negotiated cash discount for certain lab panels that include a CBC, Complete Metabolic Panel, Comprehensive Thyroid Panel, Hormones, Vitamin B12, and Vitamin D through Labcorp. If you have any of these lab panels ordered, please tell your provider which you prefer at the time of service. If you choose a cash lab option, we will collect that fee upon your check-out, and the lab will bill us directly.

Should you have any additional questions please feel free to call 949-364-4400, option 2.

We are so happy you chose to join us at the Center for Pelvic Health and Wellness!!

Sincerely,

Lisa Andrade, Office Manager

CENTER FOR
PELVIC HEALTH AND WELLNESS

DEMOGRAPHICS

Last Name_____**First Name**_____**Middle Initial** _____

Address: _____

City: _____**State:** _____**Zip Code:**_____

Cell Phone: _____**Home Phone:**_____**Work Phone:**_____

Date of Birth:____/____/____ **Gender:** _____ **SSN:** _____

Email: _____

Emergency Contact: _____**Relationship:**_____**Phone #:**_____

Primary Care Physician (PCP)_____ **Phone #:** _____

How did you hear about us (circle): Friend Doctor Internet Social Media Ad Insurance

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Pharmacy Name: _____ **Phone #:**_____

Address, City, Zip:_____ **Fax #:**_____

Responsible Party Other than Patient: _____

Phone: _____**Relationship:**_____

ASSIGNMENT & RELEASE: I HEREBY AUTHORIZE THE CENTER FOR PELVIC HEALTH AND WELLNESS (INCONTINENCE & PELVIC SUPPORT INSTITUTE-IPSI) TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND IRREVOCABLY ASSIGN TO TIIE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO ME OR MY DEPENDENTS. I HEREBY AUTHORIZE IPSI TO ACCESS, COMMUNICATE AND MAINTAIN MY MEDICATION HISTORY ELECTRONICALLY THROUGH ESCRIBE AND/OR OTHER ELECTRONIC PRESCRIPTION SERVICES IN CONNECTION WITH MY MEDICAL TREATMENT AND IN COMPLIANCE WITH IDPAA REGULATIONS.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICIES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. FOR ANY BALANCES OVER 45 BUSINESS DAYS OUTSTANDING, I UNDERSTAND THERE MAY BE A MONTHLY FEE FOR BILLING SERVICE, PLUS INTEREST. A PHOTOCOPY OR SCANNED COPY OF THIS ASSIGNMENT AND RELEASE IS AS VALID AND EFFECTIVE AS THE ORIGINAL

Name: _____**Date:**_____

Signature:_____**Relationship if Minor**_____

CENTER FOR
PELVIC HEALTH AND WELLNESS

FINANCIAL POLICIES

Payments, deductibles, and co-payments are due and will be collected at the time of your visit. Please notify us of any insurance change *immediately*

We are contracted with Medicare and most PPO insurance plans. We are contracted with three HMO's: 1)Memorial Care Medical Group, 2)Mission Hospital Affiliated Physicians and 3)Mission Heritage. We do not verify benefits nor check eligibility prior to your appointment.

Our staff will assist you to the best of their ability in dealing with your insurance company, but it is your responsibility to know and understand your insurance policy and coverage of your plan before you arrive for your visit.

Filing insurance claims is a courtesy extended to our patients and is not a guarantee of payment. It is important to emphasize that your insurance is a contract between you and the insurance carrier. Insurance plans and contracts are constantly changing.

To avoid insurance or contracting issues, we strongly encourage you to contact your insurance plan **PRIOR** to your visit and verify your benefits, eligibility and verify that the doctor you are seeing is a contracted provider and is in network prior to seeking treatment.

- You will be financially responsible for your services rendered if we do not receive payment from your insurance carrier. _____(Patient's Initials)

- Drs. Wallace, Kanaly, and Horton are participating physicians with Medicare and accept assignment for all Medicare services. Medicare pays 80% of approved charges and the patient is responsible for 20% after the annual deductible is met. Our staff will bill secondary insurance. If patient is Medi-Medi, we will bill Medicare and the remaining amount will be patient responsibility as the physicians are not contracted with Medi-Cal. _____(Patient's Initials)

- Drs. Wallace, Kanaly, and Horton are **NOT** participating physicians in Medi-Cal, Cal-Optima, and the Affordable Care Act plans, therefore we do not accept those insurances. If you do not have insurance or your insurance company does not pay for services rendered, it is the patient's responsibility to pay in full. This also applies to patients requesting services and who have out -of-network coverage. _____(Patient's Initials)

- All services rendered by Drs. Wallace, Kanaly, and Horton that are not a covered benefit of your insurance are your responsibility to pay. Any patient that is see or treated without proper authorization from their insurance carrier is responsible for full charge of the services rendered if no payment is authorized retrospectively. All monies owed by the patient (ie: co-payments, deductibles, required "out of pocket" amounts, non-covered services and co-insurance amounts) are due at the time of services rendered. _____(Patient's Initials)

CENTER FOR
PELVIC HEALTH AND WELLNESS

•If your account is placed with a collection agency, due to non-payment, you will be financially responsible for any additional charges, including monthly interest and penalty fees, collection agency fees, attorney fees, court fees, and any other associated fees in collecting the balance due. _____(Patient's Initials)

•All Virtual or Telehealth visits, telephone or video, are billable to insurance under the same guidelines as any office visit. _____(Patients's Initials)

•While we understand there may be times when our patients need to cancel their appointments, we have found it necessary to implement a "Cancellation and No-Show Policy." Any patient who fails to arrive for a scheduled appointment without canceling at least 24 hours prior to the scheduled appointment is considered a "No-Show." A "No-Show" patient schedule for an office visit may be charged $40.00. A "No-Show" patient scheduled for a procedure may be charged $100.00. No-Show charges are not billable to insurance. _____(Patients's Inititals)

We are willing to work with any patient requesting a financial payment plan. There will be a $45 charge for each check that is returned of insufficient funds.

REFUND POLICY FOR SERVICES AND PRODUCTS

There are no refunds for healthcare and aesthetic services provided by our medical staff.

This includes office visits, consultations, virtual consults, procedures such as ThermiVA, ThermiSmooth, Emsella, PTNS, Hormone Pellet Insertions, Nutritional Services and Products such as Clearmax, BioTe CORE Vitamins, Intimacy Products and V-Fit.

Unopened supplements may be returned within 30 days for credit. If you have questions about your results from taking supplements, please discuss with your provider. Any allergic reactions to supplements should be reported t o your provider, unfortunately those supplements are non-refundable.

Name:_____**Date:**_____

Signature:_____**Relationship if Minor**_____

CENTER FOR
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RECORD OF DISCLOSURES

I prefer to be contacted via: (Check all that apply):

☐ Cell Phone Number :_____

OK to leave detailed message including clinical information **YES or NO**

☐ Home Phone Number:_____

OK to leave detailed message including clinical information **YES or NO**

☐ Email:_____

OK to leave detailed message including clinical information **YES or NO**

If available, I agree to receive text message alerts about upcoming appointments:

YES or NO

I agree to receive Email correspondence about upcoming events, seasonal promotions, new services, announcements, the Center for Pelvic Health and Wellness newsletter, blog, etc.

I understand that I have the option to opt out at any time. **YES or NO**

Private Practice Acknowlegement

** NOTE: A copy of our private practice policy is available upon request.

I have received the Notice of Privacy Practices and I have been provided with an opportunity to review it.

Patient Name:_____ **DOB:**_____

Signature:_____ **Date:**_____

CENTER FOR
PELVIC HEALTH AND WELLNESS

HELPFUL TIPS FOR COMMUNICATION WITH OUR OFFICE

You and your health are very important to us.
We understand that it is sometimes hard to navigate the phone system.

PRIMARY PHONE NUMBER: (949) 364-4400 **FAX:** (949)364-2829

ONCE THE GREETING BEGINS SELECT ONE OF THE FOLLOWING EXTENSIONS

Please leave a message if your party does not answer.
Be sure to leave your full name, date of birth and a phone number where you can be reached.

APPOINTMENT SCHEDULING/RECEPTION	select **101** or **102**
MEDICAL ASSISTANT or for REFILLS and TEST RESULTS	select **107**
SURGERY SCHEDULER - AUTHORIZATON SPECIALIST	select **104**
MEDICAL RECORD SPECIALIST	select **103**
MANAGER/ADMINISTRATION (Direct Line 949-365-8845)	select **106**
BILLING OFFICE dial **949-436-0014**	

Messages received before **4:30 pm Monday – Thursday will be returned within 24 hours. Our office closes at noon on Fridays**. Messages received before noon on Friday, will be returned before the close of the business day.

If you require a prescription refill, it is best to call your pharmacy for a refill request to be sent electronically to the office – this often results in faster refills.

If you are calling after hours for an issue that cannot wait until the next day, please follow prompts to be connected to answering service.

The patient portal is a new way to communicate directly with your provider. Our staff will give you the information to set up your portal account. Portal messages will be answered throughout the day, however, it is important to note **to not send any urgent messages or urgent refill requests through the portal**. Responses to your inquiries will be answered within 2 business days. Portal messages allow for more detailed questions rather than phone messages, but your provider may decide that you need telehealth or in-office visit to completely address your concerns.

If you are experiencing an emergency, please call 911.

Thank you for your patience and support!

Drs. Wallace, Kanaly, Horton and Annelise Merriner PA-C

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PELVIC HEALTH AND WELLNESS

Patient Name: Date:

Chief Complaint: I am concerned about the following:

□ **Vaginal Bulge/Prolapse** □ **Urinary Control Issues** □ **Bowel Issues** □ **Urinary Tract Infections**

□ **Pelvic Pain/Pelvic Floor Dysfunction** □ **Blood in the Urine** □ **Painful Bladder Syndrome/IC**

□ **Other**

Bothersome Urinary Symptoms: I don't have any bothersome urinary symptoms- *skip to the next section.*

□ Urinary Frequency Urinate every _____ hours

□ Wake up to urinate at night _____ times per night

□ Do wake up wet? □ Yes □ No

□ Urgency (strong sense of needing to rush to bathroom)

□ Every time I need to urinate □ _____ % of the time

□ Do you ever leak before your get to the bathroom/toilet?

□ Yes □ No Leak _____ % of the time

□ When I leak one the way, it is:

□ Drops/Dribbles □ Gush □ Flood (lose it all)

□ What worsens your urgency?

□ Caffeine □ Exercise □ Arriving home □ Standing up

□ Sexual activity □ Alcohol □ Other _____

□ Do you leak urine with activity?

□ Coughing □ Sneezing □ Laughing □ Exercise □ Lifting

□ Sexual activity □ Walking □ Running □ Jumping

□ When I leak with activity, it is:

□ Drops/Dribble □ Gush □ Flood (lose it all)

□ I wear ____ pads per day. Type _____

□ Do you dribble urine after you have urinated? □ Yes □ No

□ Do you have pain/burning with urination □ Yes □ No

□ Feel trouble emptying bladder □ Yes □ No

□ Do you push to empty your bladder □ Yes □ No

□ My symptoms started ____ weeks ____months ____years ago

Pelvic Organ Prolapse: □ I don't have a feeling of a bulge or pressure in my vagina- *skip to the next section.*

Do you feel a sense of pelvic pressure or bulge coming out of your vagina? □ Yes □ No

These symptoms started ____ weeks ____ months ____ years ago

I feel a pressure or bulge □ Sometimes □ Most of the time □ Constantly

Does this pressure/bulge affect your ability to do your daily activities? □ Yes □ No

Does this pressure/bulge affect your ability to urinate? □ Yes □ No

Do you ever have to push on the bulge to urinate or have a bowel movement? □ Yes □ No

Do you avoid sexual activity due to the pressure or bulge? □ Yes □ No

Do you avoid sexual activity due to the pressure or bulge? □ Yes □ No

Do you have pain as result of your pressure or bulge? □ Yes □ No

If surgery is an option for this issue, do you want it? □ Yes □ No

CENTER FOR
PELVIC HEALTH AND WELLNESS

Patient Name: _____ Date: _____

Urinary Tract Infections: I don't have any issues with urinary tract infections- *skip to the next section.*

When you have a urinary tract infection, what are your symptoms?

□ Bladder pain □ Burning upon urination □ Lower abdominal pain □ Urinary frequency/urgency
□ Blood in the urine □ Fatigue □ Fever/Chills □ Nausea/vomiting
□ Confusion □ Other _____

When was your last UTI? _____ How many UTIs have you had in the last year? _____
Do you think sex is a trigger? □ Yes □ No Do you think stool (smudges/smearing) is a trigger? □ Yes □ No
Did you have UTIs as a child? □ Yes □ No Have you ever been hospitalized for a UTI or kidney infection? □ Yes □ No
What has worked for you in the past? _____

Hematuria: I have not been told or seen blood in my urine – *skip to the next section.*

Who told you that you have blood in the urine? _____ Was it on a routine urinalysis? □ Yes □ No
When did you see blood in the urine? _____
Have you been exposed to or had any of the following?
□ Prolonged chemical use (such as paint or solvents) □ Chemotherapy □ Radiation
□ Tuberculosis □ Second hand smoke □ Tobacco

Pelvic Pain: I don't have any issues with pelvic pain – *skip to the next section.*

Check all areas where you have pain or pressure:

□ Suprapubic (above the pubic bone) □ Middle Abdomen □ Groin area
□ Tail bone or sacrum □ Right kidney area (mid back) □ Outer vagina
□ Urethra □ Left kidney area (mid back) □ Deep vagina
□ Low back □ Pubic bone □ Other _____

Check all areas that describe your pain:

□ Sharp □ Cramping □ Stabbing □ Stinging
□ Burning □ Throbbing □ Dull □ Aching
□ Other _____

Is your pain ever related to or get worse with – check all that apply.

□ Sitting □ Ovulation □ Menses □ Exercise
□ Bowel movements □ Urination □ Movement □ Increased fluid intake/full bladder
□ Acidic foods □ Sexual activity □ Caffeine □ Spicy foods
□ Alcohol □ Stress □ Other _____

What makes your pain better? _____

Past Studies or Tests: Check all studies or tests that you have had before.

□ Urine analysis □ Urine cytology □ Bladder biopsy
□ Ultrasound □ Urodynamic testing □ Intravenous pyelogram (IVP)
□ MRI of abdomen/pelvis □ CT scan of abdomen/pelvis □ Cystoscopy (look into the bladder)
□ Sexually transmitted disease □ Potassium sensitivity testing □ Other _____

CENTER FOR
PELVIC HEALTH AND WELLNESS

Patient Name: _____ Date: _____

Please mark all things you have used or are currently using for your pelvic health issues:			
	Previously used	Currently used	Was it helpful?
Cranberry Juice	☐	☐	☐ Yes ☐ No
D Mannose	☐	☐	☐ Yes ☐ No
Low acid diet	☐	☐	☐ Yes ☐ No
Alcohol avoidance	☐	☐	☐ Yes ☐ No
Caffeine restriction	☐	☐	☐ Yes ☐ No
Reduced fluid intake	☐	☐	☐ Yes ☐ No
Kegel Exercises	☐	☐	☐ Yes ☐ No
Pelvic physical therapy	☐	☐	☐ Yes ☐ No
Vaginal estrogen/hormone cream	☐	☐	☐ Yes ☐ No
Hormone replacement therapy	☐	☐	☐ Yes ☐ No
Pyridium/Urogesic blue/Uribel	☐	☐	☐ Yes ☐ No
Tricyclic antidepressants (Amitriptyline)	☐	☐	☐ Yes ☐ No
Gabapentin/Lyrica/Cymbalta	☐	☐	☐ Yes ☐ No
Oxybutinin (Ditropan)	☐	☐	☐ Yes ☐ No
Oxybutinin Gel (Gelnique)	☐	☐	☐ Yes ☐ No
Oxybutinin Patch (Oxytrol)	☐	☐	☐ Yes ☐ No
Tolteridine (Detrol)	☐	☐	☐ Yes ☐ No
Fesoteridin (Toviaz)	☐	☐	☐ Yes ☐ No
Trospium (Sanctura)	☐	☐	☐ Yes ☐ No
Solifenacin (Vesicare)	☐	☐	☐ Yes ☐ No
Antihistamines (Atarax, Benadryl)	☐	☐	☐ Yes ☐ No
Valium/Xanax/Ativan	☐	☐	☐ Yes ☐ No
Elmiron	☐	☐	☐ Yes ☐ No
NSAIDS (Advil, Naproxen)	☐	☐	☐ Yes ☐ No
Opioid analgesics	☐	☐	☐ Yes ☐ No
Corticosteroids	☐	☐	☐ Yes ☐ No
SSRIs (Prozac, Zoloft, Paxil)	☐	☐	☐ Yes ☐ No
Daily suppressive antibiotics	☐	☐	☐ Yes ☐ No
Postcoital antibiotics (after sex)	☐	☐	☐ Yes ☐ No
Nitrofurantoin (Macrobid)	☐	☐	☐ Yes ☐ No
Bactrim (Sulfa)	☐	☐	☐ Yes ☐ No
Penicillin/Amoxicillin/Augmentin	☐	☐	☐ Yes ☐ No
Cephalosporins (Keflex)	☐	☐	☐ Yes ☐ No
Doxycycline/Tetracycline	☐	☐	☐ Yes ☐ No
Ciprofloxacin/Levafloxacin	☐	☐	☐ Yes ☐ No
Pessary use	☐	☐	☐ Yes ☐ No
Laser or radiofrequency	☐	☐	☐ Yes ☐ No
Acupuncture	☐	☐	☐ Yes ☐ No
Bladder instillations	☐	☐	☐ Yes ☐ No
Posterior tibial nerve stimulation	☐	☐	☐ Yes ☐ No
Botox to pelvic floor	☐	☐	☐ Yes ☐ No
Botox to bladder	☐	☐	☐ Yes ☐ No
Trigger point injections	☐	☐	☐ Yes ☐ No
Vaginal muscle relaxants	☐	☐	☐ Yes ☐ No
Hydrodistension	☐	☐	☐ Yes ☐ No
Sacral nerve stimulation/InterStim	☐	☐	☐ Yes ☐ No
Other _____	☐	☐	☐ Yes ☐ No

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PELVIC HEALTH AND WELLNESS

Patient Name: Date:

Bowel Concerns: ☐ I don't have any issues with bowel movements/constipation/loss of stool– *skip this section.*

Directions: These questions will ask you if you have certain bowel symptoms and, if you do, how much they bother you. While answering, please consider your symptoms **over the last 3 months.**

1. Please choose which stool type is the *most* like the shape of your stools - [ ] Bristol Stool image

Type 1	Type 2	Type 3	Type 4	Type 5	Type 6	Type 7
❑	❑	❑	❑	❑	❑	❑
Separate, hard lumps like nuts (hard to pass)	Sausage-shaped but lumpy	Like a sausage, but with cracks on the surface	Like a sausage or snake, smooth and soft	Soft blobs with clear-cut edges	Fluffy pieces with ragged edges, a mushy stool	Watery, no solid pieces, entirely liquid

1. How many bowel movements do you have typically _____ per day _____ per week
2. Do you feel you have to strain to have a bowel movement? ☐Yes ☐No
3. Do you feel you have not completely emptied your bowels at the end of a bowel movement? ☐Yes ☐No
4. Do you usually have pain when you pass your stool? ☐Yes ☐No
5. Do you have bleeding with bowel movements? ☐Yes ☐No
6. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement? ☐Yes ☐No
7. Do you have issues with diarrhea? ☐Yes ☐No
8. Do you ever lack the urge to have a bowel movement? ☐Yes ☐No
9. Do you ever have accidental gas or bowel leakage? ☐Yes ☐No
   a. What is the type and amount of gas or stool lost (check all that apply)

❑ Smearing in underwear ❑ Small amounts of liquid stool ❑ Large amounts of liquid stool
❑ Loss of gas ❑ Small amounts of solid stool 10. Large amounts of solid stool

   a. Do you wear a pad for this issue? ☐Yes ☐No
   b. Do you adjust your lifestyle because of concerns for possible accidental bowel leakage (for example: avoid going out, avoid certain foods, avoid sex)? ☐Yes ☐No
11. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement? ☐Yes ☐No
12. Do you have bloating? ☐Yes ☐No
13. Stomach cramps? ☐Yes ☐No
14. Rectal burning during or after bowel movements? ☐Yes ☐No
15. Feeling like you had to have a bowel movement but couldn't? ☐Yes ☐No

Have you had the following?

❑ Anal fissure ❑ Hemorrhoids

CENTER FOR
PELVIC HEALTH AND WELLNESS

Patient Name: _____ Date: _____

MEDICAL HISTORY

Please **check** all that apply: ☐ I have no medical problems – go to next section.

	Self	Siblings	Mom	Dad	GPs
ADD/ADHD/ASD	☐	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Atrial Fibrillation	☐	☐	☐	☐	☐
Bleeding Disorders _____	☐	☐	☐	☐	☐
Cancer _____	☐	☐	☐	☐	☐
Cervical Disc Disease	☐	☐	☐	☐	☐
Chronic Cough/COPD	☐	☐	☐	☐	☐
Chronic Fatigue	☐	☐	☐	☐	☐
Colitis	☐	☐	☐	☐	☐
Deep Vein Thrombosis	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Drug Addiction	☐	☐	☐	☐	☐
Eye Conditions _____	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐
Gall Bladder Disease	☐	☐	☐	☐	☐
Gastroesophageal Reflux/Ulcer	☐	☐	☐	☐	☐
Glaucoma (narrow/wide angle)	☐	☐	☐	☐	☐
Headaches/Migraines	☐	☐	☐	☐	☐
Glasses/Contacts	☐	☐	☐	☐	☐
Heart Disease _____	☐	☐	☐	☐	☐
Heart Valves	☐	☐	☐	☐	☐
Hemorrhoids	☐	☐	☐	☐	☐

	Self	Siblings	Mom	Dad	GPs
Hepatitis A, B, C	☐	☐	☐	☐	☐
HIV/AIDS	☐	☐	☐	☐	☐
Hypothyroidism/Hashimotos	☐	☐	☐	☐	☐
Hyperthyroidism/Graves/Goiter	☐	☐	☐	☐	☐
Immune System- Weak	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐
Lumbar Disc Disease	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐
Myocardial Infarction	☐	☐	☐	☐	☐
Osteoporosis/osteopenia	☐	☐	☐	☐	☐
Rheumatic Fever	☐	☐	☐	☐	☐
Renal Stones	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Shingles	☐	☐	☐	☐	☐
Skin Disorder	☐	☐	☐	☐	☐
Sleep Disorder/Apnea	☐	☐	☐	☐	☐
Spinal Cord Injury	☐	☐	☐	☐	☐
Stroke/TIA	☐	☐	☐	☐	☐
Varicose Veins	☐	☐	☐	☐	☐
Venereal Disease	☐	☐	☐	☐	☐
Weight Gain/Loss	☐	☐	☐	☐	☐
Other_____	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐

SURGICAL HISTORY

Please **circle** any surgeries that you have had indicate **year**: ☐ I have never had surgery- go to next section.

Abdominal Surgery _____
Appendectomy
Abdominoplasty/tummy tuck
Anal/Rectal Surgery_____
Back Surgery _____
Breast Implants
Breast Surgery (Lumpectomy R/L, Mastectomy R/L)
CABG _____ x Vessels
Cervical conization/LEEP
Cesarean Section (how many _____)
Cholecystectomy (removal of the gallbladder)
Cystocele Repair/Anterior Repair (w/graft- natural or mesh)
Dilation & Curettage /Endometrial Ablation
Endometriosis Surgery
Facial Surgery _____
Hernia Surgery
Hip Surgery _____Replacement R/L
Hysterectomy, for _____
Abdominal (open) Robotic Laparoscopic Vaginal
Knee Surgery_____ Replacement R/L
Laparoscopy, for_____
Labial Surgery
Pacemaker
Prolapse Surgery (w/graft- natural or mesh)
Removal of Adhesions
Removal of Tubes and Ovaries (R/L or Both)
Sling Surgery
Spinal Stimulator/ InterStim
Other _____

CENTER FOR
PELVIC HEALTH AND WELLNESS

Patient Name: Date:

MEDICATIONS Please **list all** current medications, vitamins, supplements If you have a list please provide

Name	Dosage	How often	Reason for Medication

ALLERGIES Please **list all** allergies, including drugs, iodine, shellfish, latex ☐ **I have no Drug Allergies**

SOCIAL HISTORY

Occupation: ☐ Not currently working outside the home ☐ Retired ☐ Working---Vocation_____

Relationship Status: ☐ Single ☐ Partnered ☐ Married, happily- Yes or No ☐ Separated ☐ Divorced ☐ Widowed

Tobacco: ☐ I have never smoked - go to next section.
☐ Quit smoking < 5 years ago 5-10 years ago > 10 years ago
Number of Years using Tobacco _____ Number of Cigarettes per day _____

Alcohol: ☐ I never drink alcohol - go to next section. ☐ Drinks Rarely ☐ Drinks per day 1 2 more than 2

Do you or have you used any of the following:
☐ CBD products (edibles, CBD oil, smoking, or topicals) ☐ Stimulants (cocaine, Adderall) ☐ Injectables (Heroin)
☐ Medications not prescribed to you (opioids (Percocet or Vicodin), sedatives (Valium or Xanax)

GYNECOLOGIC HISTORY

Menstrual History

Do you still have menstrual periods?
If No- why:
☐ Menopause
☐ Hysterectomy
☐ Ablation
☐ Mirena IUD
☐ OCPs
Date of last menstrual period (MM/DD/YY)_____
Are your periods?
☐ Regular
☐ Heavy
☐ Irregular
☐ Painful
Do you take Hormone Therapy? Yes or No
Type: _____
☐ I have questions about HT

Cervical Cancer Screening

Have you ever had an abnormal pap? Yes or No
Have you had treatment for an abnormal pap? If so:
When _____
What treatment _____

Have you had the HPV vaccine Yes or No

Infection History
Have you ever had ?
☐ Chlamydia
☐ Gonorrhea
☐ Recurrent yeast
☐ Herpes
☐ Recurrent BV
☐ Other _____

Pregnancy History

☐ I have never been pregnant

Number of Total Pregnancies _____
Vaginal Births _____
Cesarean Births _____
Miscarriages _____
Largest Birth _____
Forceps Yes or No
Vacuum Yes or No

Sexual History
☐ I am not sexually active
☐ I have questions about:
☐ Sex Drive
☐ Orgasm
☐ Pain with Sex

Contraceptive History

☐ I am not using contraception

I have questions about contraception Yes or No

Are you using any birth control now? _____
Past use of:
☐ Abstinence
☐ barrier method (condom)
☐ OCP
☐ IUD mirena/skyla/copper
☐ Injectable (depo-provera)
☐ Implant (implanon)
☐ Nuva ring
☐ Vasectomy
☐ Tubal Ligation
☐ Essure

CENTER FOR
PELVIC HEALTH AND WELLNESS

Patient Name: _____ Date: _____

REVIEW OF SYSTEMS	Please **circle all** symptoms that you currently have **now or in past 2 weeks**:		
Constitutional Chills Fever Weight Gain/Loss Loss of Appetite Fatigue Sleep Disturbance	**Breast** Pain Nipple Discharge Mass Implants	**Respiratory** Cough Shortness of Breath Wheezing/Asthma Use of Inhaler	**Urinary Tract** Frequent Urination Urgency Loss of Urine Frequent Bladder Infections Burning with Urination Blood in Urine
Eyes Blurred Vision/Double Vision Glasses/Contacts Eye Pain Watery eyes/Itchy Eyes	**Gastrointestinal** Reflux Constipations Diarrhea Nausea/Vomiting Change in Stools Blood in Stools Bloating Stool loss	**Neurologic** Weakness Impaired Balance Headache/Migraines Confusion Numbness/Tingling Memory Loss Brain Fog Learning Disablities	**Genitourinary** Feeling of Bulge/Vaginal Laxity Vaginal Dryness/Itching Vaginal Discharge Vaginal Mass/Lump Vaginal Pain
Ears/Nose/Throat Dry Mouth Hearing Loss Ringing in the ears Sinus Trouble Sore Throat Denture Use Allergic Symptoms	**Musculoskeletal** Joint Pain Back/Neck Pain Muscle Aches Joint Swelling Fall/Trauma Use of Cane/Walker Tight Muscles Leg Swelling	**Hematologic** Easy Bleeding Easy Bruising Blood Thinners **Endocrine** Increased thirst Changes in Blood Sugars	**Sexual/ Hormone Balance** Lack of Desire Problems with Orgasm Relationship Issues Pain with Intercourse Hot Flashes Night Sweats Mood Swings Weight Problems Brain Fog Forgetfulness Mood Changes Sleep Disturbance
Cardiovascular Chest Pain Palpitations/Irregular heart beat Murmur	**Skin** Rash/Itching Increased Hair Growth Hair Loss Acne/Eczema/Dry skin	**Emotional** Anxiety Panic Attacks Depression Irritability	

HEALTH MAINTENANCE

	Colonoscopy	Bone Density	Health Screen Lab Tests	Pap Smear	Mammogram
Month and Year of Last:	_____	_____	_____	_____	_____