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Female Pelvic Medicine & Reconstructive Surgery

Center for Pelvic Health
NavicentHealth

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NEW PATIENT MEDICAL HISTORY FORM

Name______________________________________ Date of Birth______________ Age _____________

Referring Doctor_____________________________ Primary Care MD___________________________

Best Contact number _________________________ E-mail _____________________________________

Instructions: For all new patients of the Center for Pelvic Health, Navicent Health, please complete this form prior to your appointment. Please mail (4075 Elnora Drive, Macon GA 31210) or fax (478-633-5304) this form back to us prior to your appointment.

If you are a patient that is being referred by another physician, please ensure your physician sends copies of any medical records (labs, diagnostic imaging, operative notes) to our office prior to your visit. If you are a self referral, please obtain your records and send or fax them to our office prior to your visit.

If you require further information, please contact 478-633-5300.

Thanks again and we look forward to your visit!

What are the reason for your visit? (check all that apply)

☐ Urine leakage with cough/sneeze/exercise
☐ Urine leakage with urgency
☐ Frequent urination
☐ Vaginal bulging or protrusion
☐ Inability void
☐ Bladder infections
☐ Bladder pain
☐ Loss of bowel control
☐ Complication with mesh
☐ Other: ___________________________________

What are your expectations in seeking help for this problem?

☐ Evaluation and Treatment
☐ Second Opinion

How did you hear about us?

☐ Referral from another physician
☐ Referral from a friend/family
☐ Billboard
☐ Magazine/flyer
☐ Internet Search
☐ Other: ___________________________________

Surgical History

Have you had previous surgery for incontinence? (i.e. sling) ☐ No ☐ Yes, date: ______________________
If yes, type of surgery: ____

Have you had previous surgery for prolapsed? (i.e. bladder lift)) ☐ No ☐ Yes, date: __________________
If yes, type of surgery: ____

Have you had a hysterectomy? ☐ No ☐ Yes, date: ______________________
Type: ☐ Abdominal ☐ Laparoscopic ☐ Vaginal
Ovaries: ☐ were not removed ☐ One removed ☐ Both removed

Have you had any other procedures on the urinary tract? *(check all that apply, list month/year)*

☐ Urethral dilation ____________ ☐ Cystoscopy _____________ ☐ Urodynamics _______________
☐ Collagen injections___________ ☐ Bladder Botox __________ ☐ Bladder distension___________

Other Prior Surgeries: (heart, gallbladder, appendix, D&C, etc.) ☐ No other surgeries

Date (month/year)	Surgical Procedure	Surgeon

Have you experienced problems with anesthesia with any of these surgeries? ☐ No ☐ Yes
If yes, please described what happened: ____
____
____

Medical History

Please check all Conditions that apply to you

☐Asthma
☐Blood clots
☐Cancer (Type:__________)
☐Depression/anxiety
☐Diabetes
☐GERD/Reflux
☐Heart Attack
☐Heart Disease
☐High Blood pressure
☐High Cholesterol
☐Inflammatory bowel disease
☐Irritable bowel syndrome
☐Neurologic disease
☐Stroke
☐Thyroid disease

Other conditions not listed or additional details:
____
____
____
____

Obstetrical/Gynecologic History

Total number of pregnancies: _____________

Number of vaginal deliveries: ________________________

Number of cesarean deliveries: _______________________

Were forceps used during any deliveries: ☐ No ☐ Yes ☐ Unsure

Was a vacuum used during any deliveries: ☐ No ☐ Yes ☐ Unsure

Did you ever have an episiotomy or laceration into the rectum? ☐ No ☐ Yes ☐ Unsure

Are you post-menopausal ? ☐ No ☐ Yes, age of last menstrual period: ______________________

Have you experienced any post-menopausal bleeding? ☐ No ☐ Yes

Are you taking any hormone therapy? ☐ No ☐ Yes, specify: ______________________

Are you sexually active? ☐ No ☐ Yes

If yes, do you experience pain with intercourse? ☐ No ☐ Yes

Health Screening

Date of last mammogram:_____________________	☐Normal	☐ Abnormal	☐ Never had one
Date of last colonoscopy: _____________________	☐Normal	☐ Abnormal	☐ Never had one
Date of last Pap smear: ______________________	☐Normal	☐ Abnormal	☐ Never had one

Allergies (list allergies to mediations and substances, including LATEX and BETADINE)

☐ **I have no known allergies to any medications**

Allergy	Reaction

Current Mediations (List all prescriptions, over-the-counter meds, vitamins & supplements)

Social History				
Occupation: ____				
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated				
Do you or are you…	**No**	**Yes**	**Notes**	
Smoke or use tobacco?			# per day:	# years :
Drink alcohol?			Type:	How often:
Use illegal drugs?			Type:	How often:
Exercise?			Type:	How often:
Drink caffeine (coffee, tea)?			Cups per day:	

Family History (includes only mother, father, siblings and grandparents			
Health condition	**No**	**Yes**	**List family member**
Heart disease			
High blood pressure			
Blood clots in lungs or legs			
Stroke			
Diabetes			
Kidney disease			
Cancer (please list type)			
Other			