Grand View Medical Practices Urogynecology

Name: _____ **Date of Birth:** _____

Reason for Today's Visit: _____

Primary Care Physician: _____ **Gynecologist:** _____

Do you currently see other Specialists?: (please list) _____
_____

OB/GYN History

Age of onset of first period: _____
Date of last menstrual period: _____
Your periods are (circle one):
Regular Irregular
Age at Menopause: _____
Any Postmenopausal bleeding? _____
Year of last Pap Smear?: _____
History of abnormal pap smear?:
(circle) Yes No

History of Hormone Therapy?: (circle) Yes No
Oral Patch Vaginal/IUD Implant
History of? Ovarian Cysts Fibroids
# of Pregnancies: _____ **# of Live Births**: _____
# of Miscarriages _____ **# of Terminations**: _____
Largest Birth weight: _____
Circle All That Apply: History of Forceps
Episiotomy Perineal Laceration
Vacuum Assisted Delivery Cesarean
Birth Related Pelvic Injury

Past Surgical History

Any history of Hysterectomy?: [ ] Yes [ ] No
If yes: [ ] Total [ ] Partial (ovaries and tubes conserved)
Month/Year: _____
Route (circle one): Vaginal Laparoscopic Open Abdominal Robotic
History of Tubal Ligation?: [ ] Yes [ ] No
Have you had any other type of Pelvic or Urologic Surgery?: [ ] Yes [ ] No
(Circle all that apply): Bladder Bowel Cesarean Section Gynecologic Surgery
Incontinence Kidney Urethra Ureter
If yes, list what procedure and when: _____
_____
_____

Other surgeries not related to urogynecology:

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

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Bladder Habits

How Many Times Per Day Do You:

- Void (urinate): _____
- Wake up at night to void:_____
- Have episodes of urgency: _____
- Have leaks with urgency: _____
- Have leaks with laughing, coughing, or sneezing: _____
- Have leaks with exercise, lifting, or bending over: _____
- Have leaks *without* any activity or sensation: _____

How many pads do you use to stay dry per day?: _____
Any bedwetting at night?: (circle one) Yes No
Any leakage with intercourse?: (circle one) Yes No
Do you have hesitancy to start urinating? (circle one) Yes No
Do you have to strain to maintain flow?: (circle one) Yes No
Do you have any dribbling after urinating? (circle one) Yes No
Do you have difficulty emptying your bladder completely?: (circle one) Yes No
Your urine stream is (circle what applies): Slow Interrupted Strong
Which is more bothersome, leaking with activities or leaking with urge? Or are they equally bothersome? _____

Do you perform Kegel exercises? (circle one) Yes No
Have you had any prior pelvic floor rehab or biofeedback? (circle one) Yes No
Have you used any medication to control overactive bladder? (Circle all that apply)

- Oxybutynin (Ditropan)
- Tolterodine (Detrol)
- Trospium (Sanctura)
- Darifenacin (Enablex)
- Fesoterodine (Toviaz)
- Mirabegran (Myrbetric)
- Vibegron (Gemtesa)
- Solifenacin (Vesicare)
- Estrogen Cream (Estrace)
- Premarin

Any side effects?: _____

How many caffeinated drinks per day?: _____
Number of sugar substitutes per day?: _____
Number of carbonated drinks per day?_____

Lower urinary tract symptoms: (circle all that apply)

- Blood in Urine
- Burning with urinating
- Pain with urinating
- Strong urinary odor
- Pain with full bladder
- Cloudy urine
- Frequent Urination
- Urgency

When was your last urinary tract infection?: _____

Grand View Medical Practices Urogynecology

How many urinary tract infections have you had in the last 6 months?:_____
Which medications or treatments have you used in the past to treat them?: (circle all that apply)

- Amoxicillin
- Bactrim
- Macrobid
- Keflex
- Other antibiotic (Explain):_____
- Azo
- Pyridium
- NSAIDs
- Narcotics
- Vaginal Valium
- Cystoscopy
- Physical Therapy
- Pudendal Blocks
- Uribel
- Elmiron

Pelvic organ prolapse? (Circle all that apply)

Pelvic Pressure Heaviness Sensation Vaginal Bulge seen or felt
Dullness Sensation Support to vagina or rectum to complete a bowel movement or urinate

Have you ever used a pessary?:_____ **If yes, what type?**:_____
Do you have pain with intercourse?: **(circle one)** Yes No
If yes, is the pain on entry or deep pain?: _____
Avoidance or lack of interest in sexual relations is due to: (circle all that apply)

Pain Prolapse Vaginal Dryness Incontinence

Bowel Habits

How often do you move your bowels?: (circle what applies)

- Daily
- Every other day
- _____ times per week

Bowel consistency is: (circle what applies)

- Formed
- Hard
- Soft
- Loose
- Liquid

Constipation: (Circle one) Yes No
Excessive Straining?: (Circle one) Yes No
Incomplete Bowel Emptying: (Circle one)
Yes No
Fecal Incontinence?: (Circle one) Yes No
If yes, how many times per week? ____
Any prior treatment for fecal incontinence?:
_____

Do you use any of the following: (circle all that apply)

- Stool Softeners
- Supplemental fiber
- Laxatives
- Physical Therapy
- Biofeedback

Year of last colonoscopy: _____
Findings?: _____
_____

Any history of rectal surgery: (Circle one)
Yes No
Any other previous treatments for fecal incontinence not already mentioned?:
_____
_____

GVH GRAND VIEW HEALTH

PATIENT INFORMATION

Name (Last, First, Middle)	Employer Name
Date of Birth: Sex: ☐ M ☐ F ☐ Unk	Employer's Address
Address	Employer's Phone #
City State Zip	Employer Status ☐ Full time ☐ Part time ☐ Retired ☐ Active Military ☐ Self Employed ☐ Unemployed
Email	Occupation
Primary Care Physician:	Pharmacy Name and Location
Referring Physician	

Communication Preferences

Phone Numbers

Cell:	Marital Status _____
Home:	Preferred Language _____
Work:	Interpreter Needed: ☐ Yes ☐ No
Preferred Phone # ☐ Cell ☐ Home ☐ Work	Ethnicity: ☐ Non Hispanic ☐ Other _____ ☐ Hispanic ☐ Unknown
OK to leave voice mail regarding appointment, clinical, or financial information? ☐ Yes ☐ No	Race: ☐ White ☐ African American ☐ Hispanic ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Other ☐ Patient Declined

Emergency Contact

Name (Last, First, Middle):	Permission to Disclose Healthcare Information ☐ Yes ☐ No
	Regarding Appointments? ☐ Yes ☐ No
Relationship to Patient:	Regarding Clinical Information? ☐ Yes ☐ No
Phone # ☐ Cell ☐ Home ☐ Work	Regarding Financial Information? ☐ Yes ☐ No

Person Financially Responsible ☐ check here if self

Name (Last, First, Middle)	Relationship to Patient
Address	Home Phone
City State Zip	Cell Phone

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Name	Insurance Name
Subscriber Name	Subscriber Name
Subscriber DOB	Subscriber DOB
Policy Number	Policy Number
Group Number	Group Number
Effective Date	Effective Date

Patient or Guardian Signature _____ **Date** _____

GVH GRAND VIEW HEALTH

REQUEST FOR PAYMENT AND ASSIGNMENT OF BENEFITS

I, _____ (Print Name) request payment and authorize any healthcare benefits that are otherwise payable to me by any insurance provider, benefit plan or other third party payer, under the terms of the insurance policy with _____(Insurance Company) or benefit plan to be paid directly to Grand View Health for services and goods provided by Grand View Health.

- I may be responsible for payment in full of any amount due that is not covered or paid for by any insurance policy or benefit plan for services and goods provided by Grand View Health.
- In event that I fail to make full payment or fail to comply with other payment arrangements made with Grand View Health's approval, I understand appropriate collection measure may be initiated.
- If my account is referred to an attorney or agency for collections of any unpaid balances for which I am responsible, I understand that I will also be responsible for all collection costs, including reasonable attorney's fees and court costs.
- My obligations to pay may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.
- That I am responsible to know and understand what services are covered under my insurance policy.

RELEASE OF INFORMATION

I authorize GVH and/or their agents:

- To release to my insurance provider, benefit plan, or other third party payer, or their agents, any medical or other information necessary to process related health claims, receive payment or to obtain authorization for services, supplies and equipment in accordance with HIPAA standards..
- To request and to receive directly, on my behalf, claims for benefits and/or appeals of any denied claims or authorization and to take action in my name against my insurance company, benefit plan or other third party payer, to receive any benefits that may be due or payable under the insurance policy or benefit plan.
- To give medical or other information to any healthcare practitioner furnishing health care services to me or receive information from them in accordance with HIPAA standards.

STATEMENT OF ASSISTANCE

I agree:

- To assist GVH in collections that may be due or payable under my insurance policy or benefit plan for the service, supplies and equipment provided.
- To provide any additional information needed to process the claim for payment.
- That a photocopy or other reproduction of this document shall be considered as valid as the original.

By signing below I am certifying that the information on this form is correct and current:

_____ _____

Signature of Patient or Person Authorized to Consent for Patient | Date

_____ _____

Signature of Witness | Date

If the patient is unable to sign upon arrival, state the reason: _____

GRAND VIEW HEALTH

700 Lawn Avenue
Sellersville, PA 18960
215-453-4000
www.gvh.org

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling the Privacy Officer at Grand View Health, on this organization's website, or by requesting one at this organization's offices.

_____
Date

_____
Signature

_____
Print or Type Name

- As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

_____ _____
Signature Relationship

GVH GRAND VIEW HEALTH

GVH GRAND VIEW HEALTH

700 Lawn Avenue
Sellersville, PA 18960
(215) 453-4850

MyGVH.org

Patient Portal Enrollment Form

Please complete the information below. A Grand View Health representative will set up your portal account and you will receive an email to the email address provided below with instructions to complete your enrollment within the next 2-3 business days.

I understand that patient information within the portal may include information relating to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, Behavioral Health services/psychiatric care, or treatment for alcohol and/or drug abuse.

Should you like to access patient information for someone other than yourself, please fill out an Authorization for Proxy Access to GVH Patient Portal form.

Patient Name _____

Address _____City_____State_____ Zip Code _____

Date of birth (month/day/year) _____/_____/_____

Phone Number: _____

Medical Record # (if available) _____

Email address _____

Verify Email address _____

Signature _____ Date _____

FOR STAFF USE ONLY

Patient name as shown in EMR: _____

Medical Record # as shown in EMR: _____

DOB as shown in EMR: _____

ID Verified by: _____

Enrollment completed by: _____
(Print Name)

- ☐ Patient Identification
- ☐ Photo ID
- ☐ POA Provided
- ☐ Office
- ☐ Patient Registration
- ☐ Health Information Management

Please present completed Patient Portal Enrollment Form to the Health Information Management Department with photo ID.