Florida Institute for Pelvic Health & Incontinence
at Capital Regional Medical Center

Patient Demographics

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City, State Zip: _____

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

Social Security #: _____-_____-_____ Email: _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not-Employed ☐ Retired

Employer: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Legally Separated

Race: ☐ Native American ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ African American
☐ White ☐ Hispanic or Latino

Language of Choice: _____

Emergency Information

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Home Phone: _____ Cell Phone: _____

Physician and Pharmacy Information

Referring Physician: _____ Primary Physician: _____

Pharmacy Name: _____ Address: _____ Phone #: _____

Primary Insurance Information

Name of Primary Insurance: _____ Insurance ID #: _____

Subscriber's Name: _____ Group #: _____

Subscribers' Date of Birth: _____ Co-Pay$: _____ Prescription Plan: YES NO

Secondary Insurance Information

Name of Secondary Insurance: _____ Insurance ID #: _____

Subscriber's Name: _____ Group #: _____

Subscribers' Date of Birth: _____ Co-Pay$: _____ Prescription Plan: YES NO

How did you hear about us? □ Internet □ Billboard □ Radio □ Friend/Word of Mouth

Patient (or Responsible Party) Signature: _____

Florida Institute for Pelvic Health & Incontinence at Capital Regional Medical Center

Evaluation and TREATMENT: The undersigned grants authorization to the physicians, associates, and staff at Florida Institute for Pelvic Health & Incontinence for such treatment and procedures that may be necessary. The undersigned acknowledges that no guarantees have been made as to the results of treatments or examinations in the office, or otherwise. I realize that I have the right to refuse any drugs, treatment, or procedures to the extent permitted by law.

Medicare/Commercial Insurance Authorization and Assignment: For Medicare we do accept assignment of benefits; however, we are legally required to collect your deductible and 20% coinsurance at the time of service unless you have supplemental insurance.

I request that payment of authorized Medicare, Authorized insurance benefits be made on my behalf to the service provider for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I hereby authorize payment directly to the service provider for the medical benefits if any, otherwise payable to me under the terms of my private, group employer's coverage or Medigap insurance. I hereby authorize the service provider to release any medical information necessary to process my claim. I hereby authorize that photocopies of the form be treated as originals.

_____ _____

Patient/Patient representative Signature Date

AUTHORITY TO REVIEW AND RELEASE RECORDS AND INFORMATION: The undersigned hereby authorizes and requests the physicians, associates, and staff of The Institute for Pelvic Health and Incontinence to furnish and release upon written request to all insurance companies or their representatives any and all information with respect to the patient herein named including, but not limited to, the case history, examination, prognosis, treatment medication, x-rays or surgery. Medical records may also be used for educational or research purposes with the patient protected. Authorization is hereby given to physicians, associates, and staff at The Institute for Pelvic Health and Incontinence to release patient's name, age, sex, and nature of admission and general condition.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: The undersigned understands and hereby releases physicians, associates, and staff at The Institute for Pelvic Health and Incontinence from any responsibility due to loss or damage of any valuables that the patient or the undersigned may keep in his possession in the office or hospital.

The undersigned certifies that she has read the forgoing, that it has been fully explained and that she understands its contents, and hereby agrees to all terms and conditions set forth in the above paragraphs set forth and acknowledges the receipt of a copy if requested.

_____ _____

Patient/Patient representative Signature Date

_____

Witness Signature

Florida Institute for Pelvic Health & Incontinence at Capital Regional Medical Center

MEDICAL HISTORY QUESTIONNAIRE

** ALL NEW PATIENTS PLEASE COME TO YOUR VISIT WITH A FULL BLADDER **

Name	Date of Birth	Age	Drug Allergies:	Reactions:
Please describe the reason for your visit (chief complaint)				

OBESTETRIC HISTORY

Number of Pregnancies:	Vaginal Deliveries:	Cesarean Deliveries:	Largest Baby Weight:
Forceps or Vacuum □Yes □No	Episiotomy □Yes □No	Laceration/Tear □Yes □No	
Degree/Details	Other Complications or Prolonged Labor		

GYNECOLOGIC HISTORY

Gynecologist Name:	Do you experience any of the following? (check ones you have) _____ Bleeding between periods _____ Heavy menstrual periods _____ Pain with periods _____ Bleeding after intercourse _____ Pain with intercourse _____ "Falling" of pelvic organs or prolapse
Gynecologist Phone Number:	
Date of last menstrual period:	
Date of last PAP smear: Normal?	
Date of last mammogram: Normal?	
Are you sexually active at the present time?	Are you presently taking, or have you taken in the past, hormone replacement therapy? If yes, medication and dose schedule, vaginal/oral:
Are you using contraception? If yes, what type?	

MEDICAL CONDITIONS AND MEDICATIONS

Please list ALL your medical conditions, the medication(s) you are taking for them (if any), how long you have been on the medication

Medical Condition	Name of Medication	Dosage How Often do you take it	How long have you been on the medication
Example – Hypertension	*Tenormin*	*50mg 1 daily*	*2 years*

Name	DOB	Date

PAST SURGICAL AND HOSPITAL HISTORY: □ None □Yes, if yes

Please describe your past experience with, operations, serious injuries, all and any hospitalizations and related treatments. Please include dates (month/year) of any surgeries.

FAMILY HISTORY

Are there medical events in your family's history, including diseases that may be hereditary or place you at risk? Please circle **Y** or **N** for each condition and **F** - father, **M** – Mother, **S** - Sibling (no blanks please ☺)

Condition	Yes/No	Who
Adopted	Y / N	N/A
Asthma	Y / N	F / M / S
Bleeding problems	Y / N	F / M / S
Breast Disease	Y / N	F / M / S
Breast CA	Y / N	F / M / S
Cancer (indicate type)	Y / N	F / M / S
Diabetes	Y / N	F / M / S
Heart Disease	Y / N	F / M / S
High blood pressure	Y / N	F / M / S
Kidney disease	Y / N	F / M / S
Stroke	Y / N	F / M / S
Thyroid disease	Y / N	F / M / S
Other	Y / N	F / M / S

SOCIAL HISTORY

Marital Status: □Single □Married □Widowed □Divorced □Separated

Drug / Alcohol Use Yes No Drinks/week:

Current Smoker □Yes □No # of cigarettes/day:

Former Smoker □ Yes □ No

Never Smoked □

Highest level of Education

Employment (please include job title)

Race: □Caucasian □African American □Hispanic □Asian □ American Other

Ethnicity: □Latino / Hispanic □Other □Refused

REVIEW OF SYSTEMS

Do you have or have you had any serious or chronic medical conditions?

Please Circle **Y** or **N** or any condition(s) you have had or that you have currently. (no blanks please ☺)

	Yes	No		Yes	No		Yes	No
Constitutional: Weight change	Y	N	Fatigue	Y	N			
Eyes: Vision changes	Y	N	Cataracts	Y	N	Glaucoma	Y	N
Ears/Nose/Mouth/Throat: Ulcers	Y	N	URI (upper respiratory infection)	Y	N			
Cardiovascular: Heart conditions	Y	N	Orthopnea (difficulty breathing when lying down)	Y	N	DOE (difficulty breathing on exertion)	Y	N
Respiratory: SOB(short of breath)	Y	N	Wheezing	Y	N			
Gastrointestinal: Nausea/Vomiting	Y	N	Diarrhea	Y	N			
Musculoskeletal: Weakness	Y	N		Y	N	Bloody Stool	Y	N
Integumentary/Skin: Rash	Y	N		Y	N			
Neurological: Seizure	Y	N	Syncope (fainting)	Y	N			
Psychiatric: Depression	Y	N	Anxiety	Y	N	Neuropathy	Y	N
Endocrine: Hot flashes	Y	N	Diabetes	Y	N			
Hematologic/Lymphatic: Easy bruising	Y	N	Bleeding	Y	N	Thyroid	Y	N
Allergic/Immunologic: Seasonal	Y	N	Animal Dander / Foods	Y	N	Adenopathy (Swollen Glands)	Y	N

Other:

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Name:_____

Bladder Record **Date of Birth:** _____

Please keep track of your fluid intake and urine output for two 24-hour periods. The 24-hour periods do not have to be consecutive days. Be sure to include a.m. and p.m. when documenting the time of day you urinate, and measure the amount you urinate in ounces or cc's. These markings can be found on a measuring cup. This record is very important in deciding the treatment for your bladder problems.

Day One **Type of drink**

Time	Amount Voided	Amount of Leakage	Reason for Accident	Amount of Fluid I Drank

Number of pads or undergarments used today: _____ **Date:** _____

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Name:_____

Bladder Record, continued recorded information **Date of Birth:** _____

Day Two **Type of drink**

Time	Amount Voided	Amount of Leakage	Reason for Accident	Amount of Fluid I Drank

Number of pads or undergarments used today: _____ **Date:** _____

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Michael L. Douso, M.D., F.A.C.O.G.

Dear Patient,

The Centers for Disease Control and the American College of OB/GYN have recommended that all women between ages of 19 and 64 years of age be tested routinely for HIV/AIDS.

More than 1 million people in the United States have HIV and one fourth of them don't know they have it. If they did know, they could get the medicine and treatment to help them live longer. You may choose not to have this test, please see the option below.

I am pleased to provide you with a brochure that explains about HIV and why you should be tested. I will also be available to answer any questions you may have after reading the material.

Thank you in advance for you cooperation.

_____ I would like HIV testing ordered today.

_____ I have chosen not to have HIV testing at this time.

_____ I would like more information about HIV.

Name: _____ Date: _____

2626 Care Drive, Suite 105 ● Tallahassee, FL 32308 ● Phone 850-402-3104 ● Fax 850-402-9979

Michael L. Douso, M.D., F.A.C.O.G.

Non-Covered Services Waiver Form

I _____ hereby agree to accept full financial responsibly for the following medical care received from Florida Institute for Pelvic Health and Incontinence. I am fully aware that my insurance may not cover the annual Exam/Pap Smear. If my insurance does not pay for this procedure, then I will be responsible for the balance.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature: _____ Date: _____

2626 Care Drive, Suite 105 ● Tallahassee, FL 32308 ● Phone 850-402-3104 ● Fax 850-402-9979

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NO SHOW POLICY

Missed appointments constrain our ability to care for your health needs, and the needs of other patients who could have been seen in the time set aside for you.

If you do not show up for your appointment and do not call, you may be discharged from this practice.

If you must cancel an appointment, please be considerate and call at least 24 hours in advance.

Patient Name: _____

Patient Signature: _____

Date: _____

2626 Care Drive, Suite 105 ● Tallahassee, FL 32308 ● Phone 850-402-3104 ● Fax 850-402-9979

Florida Institute for Pelvic Health & Incontinence at Capital Regional Medical Center

Michael L. Douso, M.D., F.A.C.O.G.

We appreciate you choosing The Florida Institute for Pelvic Health & Incontinence for your new patient consultation. We reserve an appointment time for you for at least forty five minutes. We will take time to do a complete exam and discuss your options.

Your new patient appointment is reserved with our practice for:

_____	_____
Appointment Date	Appointment Time

All paperwork that is enclosed in this new patient packet MUST be completely filled out and returned to our office for your reserved appointment to be confirmed. If this paperwork is not completed and returned at least one week prior to your appointment, WE WILL HAVE TO RESCHEDULE YOUR APPOINTMENT.

*If you currently wear a pessary, it **MUST** be removed one (1) week prior to your appointment.*

Thank you, we look forward to meeting you at your appointment.

• **2626 Care Drive, Suite 105, Tallahassee, FL 32308** • **850.402.3104**