



**Center for Urogynecology and Pelvic Surgery**

4735 Ogletown-Stanton Road, MAP II, Suite 1208

Newark, DE 19713

Phone: (302)623-4055 Fax: (302)623-4056

Dear \_\_\_\_\_:

Welcome to the Christiana Care Center for Uro-Gynecology and Pelvic Surgery!

Your appointment with \_\_\_\_\_ is scheduled on \_\_\_\_\_ at \_\_\_\_\_ AM/PM at the following location:

Medical Arts Pavilion (MAP) II,  
Suite 1208  
4735 Ogletown-Stanton Road  
Newark, DE 19713

Smyrna Health & Wellness Center  
100 S. Main Street  
Building C; Suite 215  
Smyrna, DE 19977

Christiana Care Concord Center  
161 Wilmington-West Chester Pike  
Chadds Ford, PA 19317

Enclosed in this packet is a medical history form as well as a current medication list for you to complete. Please list all of your medication (s) with the strength and amount you take and also how often you take them.

Also, you will find a bladder diary and also a pelvic floor questionnaire. These allow us to better understand our pelvic floor complaints. Instructions on how to complete these are found on the forms themselves.

If you have any questions regarding these papers, feel free to contact our office at the phone number listed above.

**For those patients that have an HMO insurance plan:** You are responsible for obtaining any referral you may need from your referring physician, PCP (primary/family doctor) and/ or your insurance company.

Please obtain your referral (if needed) prior to your appointment day and have a copy with you when you arrive to your appointment or have your doctor's office fax a copy to us prior to your appointment day.

\*If you are unsure as to whether or not a referral is needed, please call your insurance company for clarification.

**If your insurance requires you to pay a copay, please come prepared to pay the copay at the time of visit.** We accept cash, check and all major credit cards (except American Express).

We look forward to meeting you!

Sincerely,

Babak Vakili, MD

Howard Goldstein, DO

Emily Saks, MD

Matthew Fagan, MD

Leia Collins, PA-C

Colleen Deturk, WNHP

Helen Cohen, WHNP

Amanda Wardwell, WHNP

Center for Urogynecology and Pelvic Surgery  
Patient Registration

Patient Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Contact By: Home Cell Work Email Address: \_\_\_\_\_ Sex:  Male  Female

Marital Status: Single Married Divorced Widowed Separated Partner Other SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Race:  American Indian or Alaska Native  Asian  Asian and Black or African American  Asian and White  Black or African American  Native Hawaiian or Other Pacific Islander  White or Caucasian  Undetermined

Ethnicity:  Hispanic or Latino  Non-Hispanic or Latino  Other or Undetermined Preferred Language: \_\_\_\_\_

Employment Status: (mark all that apply)  Full-time  Part-time  Self-Employed  Retired  
 Student  Child  Unemployed  Other: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Responsible Party (Party responsible for payment): Self Spouse Parent Other \_\_\_\_\_

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ Birth Date: \_\_\_\_\_

SSN: \_\_\_\_\_ Sex: Male Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Insured Party: Self Spouse Parent Other ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ Birth Date: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Insured Party: Self Spouse Parent Other ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ Birth Date: \_\_\_\_\_

I authorize Christiana Care Health Service to release medical information to an insurance company, its intermediaries or carrier, or another physician's office. I hereby authorize direct payment of medical and/or surgical benefits, to include medical benefits to which I am entitled from Medicare, private insurance, and any other health plan to Christiana Care Health Services. I also permit copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing; I understand that, as these services were performed for me or my legal dependent, I am financially responsible for all charges whether or not paid by insurance.

X \_\_\_\_\_ X \_\_\_\_\_ / / \_\_\_\_\_  
Signature of Patient or Legal Representative Relationship of Patient, Date Time:  
If Legal Representative

Interpretation: The information presented orally to the  patient  representative  decision maker was interpreted into (language) \_\_\_\_\_ . The person for whom the information was interpreted stated s/he understood the interpretation.

X \_\_\_\_\_ X \_\_\_\_\_ / / \_\_\_\_\_  
Interpreter Name/ Agency ID# Staff Signature/ Title Date Time:



Name: \_\_\_\_\_ Date of Birth (MM/DD/YY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_

Provider referring you for this visit (if applicable): \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

Date of last gynecological visit: \_\_\_\_\_ Location/Provider: \_\_\_\_\_

Reason for Visit: _____ _____	Anything else you wish to discuss today: _____ _____ _____
Do you have an advanced directive (living will)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you experiencing pain? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, rate on a scale of 0-10 (0 being no pain, 10 being the worst)</i> Pain at rest: ____/10 Pain with activity: ____/10

Does the patient have a home care giver?  Yes  No  Declined  Unable to Verify  N/A  Other: \_\_\_\_\_

Home Caregiver Name/Relationship: \_\_\_\_\_ Home Caregiver Preferred Phone Number: (\_\_\_\_)-\_\_\_\_-\_\_\_\_

**LEARNING METHODS:**

Do you have any Learning Barriers/Factors Affecting Learning?				
<input type="checkbox"/> None at this time	<input type="checkbox"/> Cultural barrier	<input type="checkbox"/> Emotional state	<input type="checkbox"/> Language barrier	<input type="checkbox"/> Vision
<input type="checkbox"/> Acuity of illness	<input type="checkbox"/> Desire/Motivation	<input type="checkbox"/> Financial concerns	<input type="checkbox"/> Literacy	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cognitive deficits	<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Hearing deficit	<input type="checkbox"/> Memory problems	_____

**GYN MENSTRUAL STATUS:**

<b>Menstrual Status</b>	
Date of last menstrual period: _____	<input type="checkbox"/> Postmenopausal <input type="checkbox"/> Hysterectomy
Are you currently on hormone therapy? (Please circle) Yes No	
Pregnancy Prevention/Contraception: <input type="checkbox"/> N/A	
<input type="checkbox"/> Condom	<input type="checkbox"/> Pills <input type="checkbox"/> Other _____
<input type="checkbox"/> Depo Shot	<input type="checkbox"/> Rhythm or Withdrawal <input type="checkbox"/> Ring
<input type="checkbox"/> IUD (Intrauterine Device)	<input type="checkbox"/> Spermicide <input type="checkbox"/> Patch
<input type="checkbox"/> Implant/Nexplanon	<input type="checkbox"/> Sterilization:
	<input type="checkbox"/> Tubal ligation
	<input type="checkbox"/> Tubal occlusion
	<input type="checkbox"/> Hysterectomy
	<input type="checkbox"/> Partner vasectomy

<b>If you are menopausal, please complete section below (please circle where appropriate):</b>
Age/year periods stopped: _____
Hysterectomy? Yes No
Hormone therapy? Yes, currently taking Yes, taken in the past Never taken
Hot Flashes? Yes No
Vaginal Dryness? Yes No
Postmenopausal bleeding? Yes No
Mood Symptoms? Yes No
Insomnia? Yes No
Bowel Issues? Yes No




**ALLERGIES:** List all drug, environment and food allergies below

 No known allergies

Substance	Type of Reaction

**MEDICATIONS:** List all current medications and how they are taken. INCLUDE VITAMINS and OVER THE COUNTER MEDICATIONS

 No Current Medications

Medication Name	Dose	How often do you take it?	Medication Name	Dose	How often do you take it?

PREFERRED PHARMACIES	Name	Location	Phone Number
Local Pharmacy			
Mail Order Pharmacy			

**SOCIAL HISTORY:**

**Alcohol Use:**     Current                       Past                       Never

What Type:     Beer                       Wine                       Liquor                       Other: \_\_\_\_\_

Frequency:     1-2 times per year     1-2 times per month     1-2 times per week     3-5 times per week     Daily

Several times per day     Other: \_\_\_\_\_

**Tobacco Use:**     Smoker, current status unknown     Never (less than 100 lifetime)

**Frequency/PPD?:**     4 or less cigarettes (*less than ¼ pack*)/day in last 30 days     5-9 cigarettes (¼ - ½ pack)/day in last 30 days     10 or more cigarettes (½ pack or more)/day in last 30 days

Cigars or pipes daily within last 30 days     Cigars or pipes but not daily within last 30 days     Former smoker, quit more than 30 days ago

**Tobacco Type:**     Cigarettes                       Cigars                       Oral/Chewed                       Pipe                       Vape                       Other: \_\_\_\_\_

Tobacco use per day: _____	Number of years: _____	Age started: _____	Age stopped: _____	Smoker in Household: <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Substance Abuse:**     Current                       Past                       Never

If current or past, what type?: \_\_\_\_\_

Have you ever used street drugs with a needle?     Yes     No

Frequency:     1-2 times per year     1-2 times per month     1-2 times per week     3-5 times per week     Daily

Several times per day     Other: \_\_\_\_\_

Type:    Amphetamines                      Hallucinogens/LSD                      Marijuana                      Other

                    Cocaine                      Heroin                      Methamphetamine

                    Ecstasy                      Inhalants/Glues/Solvents                      Prescription Medications





Pt Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**Instructions:** Please answer these questions by putting a X in the appropriate box. If you are unsure about how to answer a question, give the best answer you can. While answering these questions, please consider your symptoms over the last 3 months.

1. Do you usually experience *pressure* in the lower abdomen?  No;  Yes  
0

If yes, how much does this bother you?

1       2       3       4  
Not at All - Somewhat - Moderately - Quite a bit

2. Do you usually experience *heaviness or dullness* in the pelvic area?  No;  Yes  
0

If yes, how much does this bother you?

1       2       3       4  
Not at All - Somewhat - Moderately - Quite a bit

3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?  No;  Yes  
0

If yes, how much does this bother you?

1       2       3       4  
Not at All - Somewhat - Moderately - Quite a bit

4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?  No;  Yes  
0

If yes, how much does this bother you?

1       2       3       4  
Not at All - Somewhat - Moderately - Quite a bit

5. Do you usually experience a feeling of incomplete bladder emptying?  No;  Yes  
0

If yes, how much does this bother you?

1       2       3       4  
Not at All - Somewhat - Moderately - Quite a bit