OFFICE USE ONLY:

WT _____ HT _____

BP_____

Lakeside Doctors

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Urogynecology of Oklahoma, PLLC.

Patient Name: _____ Date of Birth: _____

Referring Physician: _____ Primary Physician: _____

Preferred Pharmacy: _____

Pharmacy phone number and/or location: _____

Please describe the nature of the problem that brought you to our clinic:

_____

_____

_____

_____

Have you seen any other physicians for this problem? NO YES

If yes, please list the physician(s) and any evaluation or therapy:

_____

_____

_____

When did this problem start? _____

What have you tried for relief? _____

What makes the problem better? _____

Does anything worsen the problem? _____

How severe is the problem now? _____

Allergies

Medication(s) you are allergic to:

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

☐ No Known Drug Allergies

Patient Name: _____ Date of Birth: _____

Current Medication

Medication Name	Dose	Frequency	Prescribing Physician

Patient Name: _____ Date of Birth: _____

Please **check** any medical problems **YOU** were diagnosed with as an adult:

☐Asthma	☐Blood Clots (DVT's, etc.)	☐Bladder Cancer	☐COPD
☐Diabetes	☐Heart Attack	☐Heart Disease	☐Heart Murmur
☐High Blood Pressure	☐Lupus	☐Ovarian Disease	☐Pelvic Radiation
☐Pulmonary Embolism	☐Stroke	☐Thyroid Disease	☐Uterine Cancer

Other Cancer: _____

Serious Injuries (please explain):_____

_____

Other Medical Diagnoses (Problems)	**Date of Diagnosis**	**Treating Physician**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been diagnosed with Hepatitis C or HIV/AIDS? _____

If YES: Type: _____ When was diagnosis confirmed?_____

Do you have Diabetes? _____ If YES: Type: _____

What medication or treatment plan are you currently on for diabetes? _____

_____

Surgical History

Appendectomy	Reason and Date of Surgery: _____
Bladder Tack	Reason and Date of Surgery: _____
Bowel Surgery	Reason and Date of Surgery: _____
Burch	Reason and Date of Surgery: _____
Cystocele Repair	Reason and Date of Surgery: _____
Exploratory Laparotomy	Reason and Date of Surgery: _____
Gallbladder Removal	Reason and Date of Surgery: _____
Hysterectomy - Ovaries Removed? Y/N	Reason and Date of Surgery: _____ - If yes, please circle: Both Ovaries Right Ovary Left Ovary

Patient Name: _____ Date of Birth: _____

Surgical History Continued

Laparoscopy — Reason and Date of Surgery: _____

MMK — Reason and Date of Surgery: _____

Rectocele Repair — Reason and Date of Surgery: _____

Sling — Reason and Date of Surgery: _____

Tubal Ligation — Reason and Date of Surgery: _____

Urethral Bulking (collagen or other material) — Reason and Date of Surgery: _____

Other Abdominal Surgeries _____ — Reason and Date of Surgery: _____

Other Surgeries/Hospitalizations	Date	Hospital
_____	_____	_____
_____	_____	_____

Pregnancy History

All Pregnancies _____ Miscarriages _____ Abortions _____ Living Children _____

Birth Date	Birth Weight	Weeks/Months of Pregnancy	Type of Delivery	Tears into Rectum
___/___/_____	_____	_____ weeks/months	Vaginal/C-Section/Vacuum/Forceps	Y / N
___/___/_____	_____	_____ weeks/months	Vaginal/C-Section/Vacuum/Forceps	Y / N
___/___/_____	_____	_____ weeks/months	Vaginal/C-Section/Vacuum/Forceps	Y / N
___/___/_____	_____	_____ weeks/months	Vaginal/C-Section/Vacuum/Forceps	Y / N

Gynecology History

Age of first Period: _____

First day of last menstrual cycle: _____ Age of menopause (if applicable): _____

How often do you have a menstrual cycle: _____ Length of bleeding _____

If abnormal cycles, please explain: _____

Are you sexually active? Y / N Is it painful? Y / N Which birth control (if any) do you use: _____

History of sexually transmitted disease? Y / N If yes, please explain: _____

History of abnormal pap smears? Y / N If yes, when: _____

Were any procedures done to your cervix for the abnormality? _____

Patient Name: _____ Date of Birth: _____

Social History

Do you smoke cigarettes? Y / N If yes, how many packs: per day _____ years _____

Have you smoke in the past? Y / N If yes, when did you quit: _____

Do you use electronic cigarettes/vape? Y / N If yes, how long have you been using: _____

Do you smoke any other form of tobacco or other product? Y / N If yes, what kind: _____

Do you drink alcohol? Y / N If yes, how much: _____

Do you use street drugs? Y / N If yes, please describe: _____

Do you exercise regularly? Y / N If yes, please describe: _____

Do you drink caffeine? Y / N If yes, please describe: _____

Family History

Has anyone in your family had any of these diseases? If so please give relationship to you.

Breast Cancer _____ Colon Cancer _____

Heart Disease _____ Ovarian Cancer _____

Prolapse (including cystocele or rectocele _____

Urinary Incontinence _____

Other Disease(s), please list _____

Preventative History

Date of last pap smear _____ Were the result normal? Y / N

Have you ever had an abnormal pap? Y / N If yes, please explain: _____

Date of last mammogram _____ Were the results normal? Y / N

Have you ever had an abnormal mammogram? Y / N If yes, please explain: _____

Date of last colonoscopy _____ Were the results normal? Y / N

Have you ever had an abnormal colonoscopy? Y / N If yes, please explain: _____

Other

How many times a day do you urinate? _____

How many times a night do you urinate? _____

Have you ever tried over active bladder medications in the past? Y / N

If yes, please list medications you have tried: _____

How frequent are your bowel movements? _____ daily / weekly

Do you have any difficulty with your bowel movements? Y / N

Do you take anything to help with constipation? Y / N

If yes, what do you take? _____

Patient Name: _____ Date of Birth: _____

Please circle the appropriate number for your symptoms					
	NO	**Not at All**	**Somewhat**	**Moderately**	**Quite a Bit**
Do you usually experience pressure in the lower abdomen?	0	1	2	3	4
Do you usually experience heaviness or dullness in pelvic area?	0	1	2	3	4
Do you usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1	2	3	4
Do you ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1	2	3	4
Do you usually experience a feeling of incomplete bladder emptying?	0	1	2	3	4
Do you ever have to push on a bulge in the vaginal area with your fingers to start or complete urination?	0	1	2	3	4
Do you feel you need to strain too hard to have a bowel movement?	0	1	2	3	4
Do you feel you have not completely emptied your bowels at the end of a bowel movement?	0	1	2	3	4
Do you usually lose stool beyond your control if your stool is well formed?	0	1	2	3	4
Do you usually lose stool beyond your control if your stool is loose?	0	1	2	3	4
Do you usually lose gas from your rectum beyond your control?	0	1	2	3	4
Do you usually have pain when you pass your stool?	0	1	2	3	4
Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowl movement?	0	1	2	3	4
Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1	2	3	4
Do you usually experience frequent urination?	0	1	2	3	4
Do you usually experience urine leakage associated with a feeling of urgency, which is a strong sensation of need to go to the bathroom.	0	1	2	3	4
Do you usually experience urine leakage related to coughing, sneezing or laughing?	0	1	2	3	4
Do you usually experience small amounts of urine leakage (that is, drops)?	0	1	2	3	4
Do you usually experience difficulty emptying your bladder?	0	1	2	3	4
Do you usually experience pain or discomfort in the lower abdomen or genital region?	0	1	2	3	4

Patient Name: _____ Date of Birth: _____

<u>In the past 7 days, have you been bothered by any of the symptoms below?</u>

If so, please circle all that apply.

Constitutional: Fever Fatigue Weight Change Loss of Appetite

Eyes: Eye Pain Blurry Vision Loss of Vision

ENMT: Swollen Neck Glands Loss of Hearing

Cardiovascular: Chest Pain Heart Palpitations Leg Swelling Fainting Heart Murmur

Respiratory: Shortness of Breath Wheezing Frequent Coughing

Gastrointestinal: Abdominal Pain Constipation Diarrhea Blood in Stool Vomiting Nausea Decreased Appetite

Genitourinary: Abnormally Heavy Bleeding Irregular Menstrual Cycles Painful Intercourse Abnormal Discharge Urinary Urgency Urinary Frequency Painful Urination Blood in Urine

Musculoskeletal: Joint Pain Joint Stiffness Back Pain Difficulty Walking Muscle Pain Muscle Weakness

Neurological: Frequent Headaches Frequent Dizziness Seizures

Skin: Rash Itching

Breast: Breast Mass Breast Pain Nipple Discharge

Psychiatric: Depression Anxiety Memory Loss or Confusion

Endocrine: Diabetes Hyperthyroidism Hypothyroidism

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Lakeside Doctors

Patient Information / Disclosure Agreement

Doctor: _____

Patient Last Name: _____First Name: _____Middle Init: _____

Address: _____ City: _____State: _____Zip: _____

Home #: _____Work#: _____Ext: _____Mobile: _____

Date of Birth: _____SS#: _____-_____-_____Marital Status: _____

E-mail: _____Race: _____

Primary Care Physician:_____ Phone Number:_____

Pharmacy:_____ Pharmacy Address: _____

Employer: _____Occupation: _____

Emergency Contact: _____Relationship: _____Phone #: _____

All Lab/blood work will be sent to the hospital's contracted lab.

REASON FOR TODAY'S VISIT

☐ **Routine Preventative Exam:** (I have no medical complaint or problem of which I am aware.) **Medicare will not cover.**

☐ **Routine Preventative Exam AND the Following Problem** that I wish to be evaluated/ treated:

_____

☐ **I have a Problem/ Complaint** that I wish to have evaluated/ treated. My Chief Complaint Is:

Physicians of NW Oklahoma City, LLC (Arielle Allen, Susan L. Chambers, Elizabeth A. Pinard, Jennifer K. Nelson, Valerie A. Engelbrecht, Dana G. Stone, Margaret A. Hall, D. Nelson Fong, Whitney C. Driver, Lisa Wasemiller-Smith, and William Miller) are owners of Lakeside Women's Hospital. We refer patients there because it is convenient and efficient for patients, and the quality of care is excellent. We believe that patients have a choice in the selection of health care facilities. If you wish to use another facility, please let us know.

I hereby authorize the physicians of the Lakeside Doctors to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Lakeside Doctors all payments for medical services rendered to myself or my dependents. I understand that the information authorized for release may include information, which may be considered a communicable, or venereal disease.

Lakeside Women's Hospital has arranged for one or more physicians to be on on-site at the Hospital and available to respond for medical emergencies during most hours of operation. However, we cannot guarantee that a physician will be present at the Hospital at all times. The Hospital has taken certain measures to ensure that qualified and properly trained medical personnel are available to respond to any medical emergency that may arise when a physician is not present at the Hospital.

I agree to pay for any and all medical services I receive from the doctor that my insurance company refuses to pay, for whatever reason. This office will file a claim in my behalf (if contracted). I will pay these charges upon written/ verbal notice of their refusal. Failure of your insurance company to pay within 45 days of claim filing date will be considered a refusal to pay.
I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my Medical records. Thus to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.
In the event I do not pay charges when due, for these or any other services provided me, I agree to pay all cost of collection, including reasonable attorney fees.

I am aware that if laboratory (including pap smear, blood and urine testing, and biopsies) is obtained, there will be a separate charge from the pathology laboratory for this exam.

Patient Signature: _____Date: _____

Parent Signature if Minor: _____Date: _____

A photocopy of the authorization and assignment shall be considered as valid as the original.

Lakeside Doctors

Permission for Disclosure of Protected Health Information

I hereby acknowledge that I received a copy of this medical practice's *Notice of Privacy Practices*. I further acknowledge that I will be offered a copy of any amended *Notice of Privacy Practices* at each appointment.

I, _____, give my permission for Lakeside Doctors to give information to the people listed below about my medical care. This information may include lab results, medications being taken, appointments times, changes in appointments, x-ray results, doctor or nurse reports about me and any other information that this office has about me.
(Please DO NOT include other physicians or your employer in this list).

I understand it is my responsibility to keep this office updated on any changes to my personal information.

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ _____
Signature of Patient (or Parent/Guardian if minor) Date

_____ _____
Witness Signature Date

OPPORTUNITY TO OBJECT

I, _____, do not want any information given to anyone but myself regarding my healthcare status or other patient information.

_____ _____
Signature of Patient (or Parent/Guardian if minor) Date

_____ _____
Witness Signature Date