# Aimee Nguyen, M.D.
# PATIENT INFORMATION SHEET

| Name | | Date of birth | | Age |
|---|---|---|---|---|
| Address | | City | State | Zip |
| Home Phone | Work Phone | | Cell Phone | |
| Social Security # | | Marital Status: M S W D | | |
| Race: | Language: | | E-mail Address: | |
| **Emergency Information** | | | | |
| Emergency Contact Name | | Relationship | | |
| Emergency Contact Home Phone | Work Phone | | Cell Phone | |
| **Pharmacy Information** | | | | |
| Pharmacy Name | Address | | Phone Number | |
| Patient Employer Information | | Spouse's Information | | |
| Patient's Employer | | Spouse's Name | | |
| Occupation | | Spouse's Employer | | |
| **Primary Insurance Information** | | | | |
| Name of Primary Insurance | | Insurance ID # | | |
| Subscriber's Name | | Group # | | |
| Subscriber Date of birth | | Co-Pay $ | Prescription Plan: Yes No | |
| **Secondary Insurance Information** | | | | |
| Name of Secondary Insurance | | Insurance ID # | | |
| Subscriber's Name | | Group # | | |
| Subscriber's Date of Birth | | Co-Pay $ | Prescription Plan: Yes No | |

## Insurance Authorization and Assignment

I authorize North Dallas Urogynecology, PLLC to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for release services. I authorize the payment of all benefits to North Dallas Urogynecology, PLLC. I understand that I am ultimately responsible for all services whether covered by insurance or not. I authorize my physician, based on his/her discretion, to access my chart for utilization management review and to view my prescription history from external sources.

Date ________________________________ Signature ________________________________________

## Release of Information Authorization

Please mark below for release of information concerning your healthcare and/or financial arrangements:

Release information ONLY to me: ___ Yes ____ No
Release of Information to Spouse: ___ Yes ____ No
Spouse's Name: ________________________________

Release of Information to Other Individual: ___ Yes ____ No
Name & Relationship: ____________________________
Phone #: ______________________________________

## Preferences

I prefer to be contacted in the following manner:

Phone#: ( ) ______________________

- ☐ Leave message with detailed information.
- ☐ Leave message with contact number only.
- ☐ Do not leave message.

I am fully aware my health information will be transmitted by electronic transmission, fax transmittal, internet or e-mail.

Signature _______________________________________________________ ________________
Patient/Guardian Date

## Consent to receive text messages about appointment reminders:
## Patients in our practice

I ___________________ consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number to receive appointment reminders. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing.

- The **CELL PHONE NUMBER** that I authorize to receive

  TEXT Reminders
  - Is: (_____) ________-________

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details)

**North Dallas Urogynecology**
**Female Pelvic Medicine and Reconstructive Surgery**

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MEDICAL HISTORY QUESTIONNAIRE

Name:____________________________ Age:_________ Date: _____________________

| Primary Care Physician: | Gynecologist: |
|---|---|
| Name: _______________________ | Name: ______________________ |
| Address: _____________________ | Address: ______________________ |
| _______________________ | _______________________ |
| Phone: _____________________ | Phone: _______________________ |

Name of previous Urologist (if applicable): ___________________________

Whom may we thank for referring you to us? _______________________

Please describe in your own words the nature of your gynecologic problems':

______________________________________________________________________

______________________________________________________________________

When did you first become aware of the problem? _____________________________________________

Describe any previous treatments (medicines, surgery, etc.) prior to this visit:________________________

**Allergies**: Do you have any drug allergies? Y N
If yes, please include name of drug or x-ray dyes and **describe the type of allergic reaction**:

______________________________________________________________________

______________________________________________________________________

**Medical History:**

As an Adult have you had (please circle):

| | | | |
|---|---|---|---|
| Heart Disease | High Cholesterol | Reflux/GERD | Depression |
| High Blood Pressure | Stomach Ulcers | Seizure disorder | Anxiety Disorder |
| Diabetes | Kidney Disease | Paralysis | Psychiatric Illness |
| Anemia | Liver Disease | Hepatitis B/C | Glaucoma |
| Thyroid Disease | Kidney/Bladder stones | Back Problems | Serious injury/Accident |
| Blood clots | Bleeding problems | Multiple Sclerosis | Parkinson's disease |
| Stroke or TIAs | Heart Attack | Frequent Bladder Infections | Abnormal pap smears |
| Chronic cough | Asthma | Emphysema/COPD HIV | Congestive Heart Failure |

Cancer, if yes, what type____________________what type of treatment:________ List other medical conditions not listed above:____________________________________________________________

**Surgical History**

Have you had a hysterectomy? Y/N

*If yes…For what reason?*____________

*…at what age?*

*What type of incision? Abdominal* _____ *Vaginal*____ *Laparoscopic*_____

Have you had your ovaries removed? Y N

Have you had any surgeries for incontinence or bladder problems? Y N

*If yes…what type and what age?*___________________________________

Please list any other operations you've had and your age at the time:

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

**Family& Social History**

Have any first degree relatives had these diseases? If so, please indicate their relationship to you.

High blood pressure ______________________ Heart Disease ____________________

Stroke ____________________ Diabetes ____________________

Cancer (please list type) ____________________ Kidney Disease ____________________

Breast Cancer ____________________ Osteoporosis ____________________

Blood/Clotting Disorder ____________________ Relaxation of Uterus or Vagina ____________________

Ovarian Cancer ____________________ Urinary Incontinence ____________________

Other family or Hereditary Diseases_________________________________________________________

Are you a: current smoker ☐ former smoker ☐ non- smoker ☐

If yes…how many packs per day __________ How many years?_________

Do you drink alcohol? Y N

If yes…how many drinks per week___________

Do you use recreational drugs? Y N

Your occupation________________

Current marital status (circle one): Single Married Divorced Widowed

Number of pregnancies _______ Number of Children ________

Number of miscarriages _______ Number of abortions ________

Date of Last Menstrual Period:____________

**Medications:** Please list all current medications (including hormones, contraceptives, vitamin, and dosages)

| Medication | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Symptoms Review:** Please circle any symptoms you've had in the past few months:

| General Symptoms | Hematologic/Allergy | Gastrointestinal | Cardiovascular |
|---|---|---|---|
| Fever/Chills | Clotting Problems | Abdominal pain | Chest pain |
| Change in appetite | Swollen Glands | Diarrhea | Shortness of Breath |
| Headache | Hay fever | Blood in stools | Varicose Veins |
| Wt. loss/gain>10lbs. | Prolonged bleeding | Indigestion | Swelling of legs |
| Nausea/vomiting | Easy bruising | Constipation/Bloating | |

| Neurological | Endocrine | Musculoskeletal | ENT |
|---|---|---|---|
| Memory Loss | Excessive thirst | Joint pain | Hearing Loss |
| | | | Visual change |
| Dizzy spells | Intolerance to hot/cold | Back pain | Cold |
| Tingling | Excessive fatigue | Weakness | Cough |
| Numbness | | | Sore throat |
| Insomnia | | | Blurred vision |
| Tremors | | | Dry Eyes |
| Loss balance | | | History of glaucoma |

| Skin | Respiratory | Gynecologic | Psychiatric |
|---|---|---|---|
| Skin Rash/Boils | Wheezing | Breast pain or lump | Depressive symptoms |
| Change in- | Frequent cough | Hot flashes | Thoughts of suicide |
| Appearance of mole | Cough up blood | Vaginal Bleeding | Anxiety |
| Change in size of mole | Trouble breathing | Vaginal discharge | High Stress level |
| | | | Difficulty Remembering |

Name________________________________________ Date_____________________

*While answering these questions, please consider your symptoms over the last 3 months. We realize that you may not be having problems in some of these areas.*

| *Do you experience, and, if so, how much are you bothered by…..* | *Not at all* | *Somewhat* | *Moderately* | *Quite a bit* |
|---|---|---|---|---|
| Usually experience pain in the lower abdomen or Genital region? | | | | |
| Usually experience heaviness or pressure in the pelvic | | | | |
| Usually have a bulge or something falling out that you can see or feel in the vaginal area? | | | | |
| Usually experience a feeling of incomplete bladder Emptying? | | | | |
| Feel you need to strain too hard to have a bowel Movement? Constipation? | | | | |
| Feel you have not completely emptied your bowel at the end of a bowel movement? | | | | |
| Ever have to push on the vagina or around the rectum | | | | |
| Usually lose stool beyond your control, if your stool is well formed or loose? | | | | |

1) Do you leak urine with activities such as: coughing gently/hard, sneezing, laughing, lifting, bending, jumping, and jogging or exercise?
   - If yes, how often? #Times____/day or # times'____/week. For how many years? ____
     i. Please circle which activities above that this occurs with.
     ii. Is this socially bothersome? Yes or No

2) When you get the urge to urinate, you might lose urine before you get to the toilet in time? Yes or No
   - If yes, how often? #Times____/day or # times_______/week. For how many years? ____
     i. Is this socially bothersome? Yes or No

3) How often do you typically get the urge to urinate on average?
   - _____ Every 30m – 1hr _____ Every 1hr – 2hr
   - _____ Every 2hr – 3hr _____ Every 3hr – 4hr
     i. Is this socially bothersome? Yes or No

4) How often do you wake up at night to urinate?____
   - Do you wake up at night due to urge or are you a light sleeper?

5) Do you leak urine without any warning or movement at all? Yes or No
   - If yes, how often? # Times____/day or # time's ______/wks.

6) Do you ever wet your bed at night when sleeping? Yes or No
   - If yes, how often? # Times______/day or # time's______/wks.

**Labiaplasty**

Are you dissatisfied with the appearance of your labia due to length, pigmentation, size, or asymmetry? Yes or No

**Vaginal Rejuvenation**

Does your vagina feel loose with minimal muscle tone? Yes or No