

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		
Ethnicity:		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

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?

Vaginal

Laparoscopic

...at what age?

What type of incision? Abdominal

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 miscarriages

Number of
Children

Number of
abortions

Date of Last Menstrual Period: _Vaginal delivery/C-section

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

Fever/Chills
Change in appetite
Headache
Wt. loss/gain>10lbs.
Nausea/vomiting

Hematologic/Allergy

Clotting Problems
Swollen Glands
Hay fever
Prolonged bleeding
Easy bruising

Gastrointestinal

Abdominal pain
Diarrhea
Blood in stools
Indigestion
Constipation/Bloating

Cardiovascular

Chest pain
Shortness of Breath
Varicose Veins
Swelling of legs

Neurological

Memory Loss

Dizzy spells
Tingling
Numbness
Insomnia
Tremors
Loss balance

Endocrine

Excessive thirst

Intolerance to hot/cold
Excessive fatigue

Musculoskeletal

Joint pain

Back pain
Weakness

ENT

Hearing Loss
Visual change

Cold
Cough
Sore throat Blurred
vision Dry Eyes
History of glaucoma

Skin

Skin Rash/Boils
Change in-
Appearance of mole
Change in size of mole
Difficulty Remembering

Respiratory

Wheezing
Frequent cough
Cough up blood
Trouble breathing

Gynecologic

Breast pain or lump
Hot flashes Vaginal
Bleeding Vaginal
discharge

Psychiatric

Depressive symptoms
Thoughts of suicide
Anxiety
High Stress level

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 Area?				
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 To have or complete a bowel movement?				
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