Board Certified Urogynecologists:
Barbara R. Henley, MD
Jennifer L. Lanzer, MD

Urogynecology Physician Assistant:
Melania Velasquez, PA-C

Female Pelvic Medicine & Reconstructive Surgery
Appointments: (706) 446-5901 • Nursing (706) 446-5906 •Fax (706) 651-7400
2834 Hillcreek Drive, Augusta, GA 30909

We are looking forward to your upcoming visit with Urogynecology (Female Pelvic Medicine & Reconstructive Surgery) at Augusta University Women's Health at Hillcreek.

In order to facilitate your visit, please complete the following forms before your scheduled appointment. These forms will be collected when you check-in for your appointment.

If you have any questions prior to your visit, please contact our office or visit our website at **www.augustahealth.org/urogyn**.

Appointment with

Barbara R. Henley, MD **Jennifer Lanzer, MD**

Melania Velasquez, PA-C

Date: _____ Time: _____

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Last Name_____First Name_____Birthdate_____Age_____

Preferred Name _____

Do any of these describe you? ☐ Intersex ☐ Transgender ☐ Gender fluid

Referring Physician:

Name_____

Address_____

City_____State_____Zip_____

Primary Care Physician:

Name_____

Address_____

City_____State_____Zip_____

Pharmacy_____

Phone No._____

Address_____

City_____State_____Zip_____

Today's Visit:

What is the main reason you came to the office today?

_____

_____

_____

When did it start?

_____

What treatments have you had so far for this health issue?

☐ Kegel exercises? ☐ Medications? If so, what medications_____
☐ Pessary? ☐ Vaginal estrogen cream? ☐ Pelvic floor physical therapy?
☐ Other?_____

URINARY INCONTINENCE

Do you experience leakage of urine? YES / NO If yes, how long? _____months _____years	Do you leak urine when you cough, sneeze, or laugh? YES / NO
After you urinate, do you have dribbling? YES / NO	Do you leak urine with urgency or on the way to the bathroom? YES / NO
Please check if you leak urine during the following times: ☐ Walking ☐ Running ☐ Urgency ☐ Changing from sitting to standing ☐ Lying down ☐ Exercise ☐ Straining or lifting ☐ With Intercourse ☐ Minimal activity	
Do you use a pad for urine leakage? YES / NO If yes, how many a day?_____	How long can you postpone emptying your bladder when you have the urge to urinate? _____minutes or ____hours
Do you ever wet the bed while sleeping? YES / NO	What amount of leakage do you experience? ☐ Drops ☐ More than drops ☐Flood ☐ Leak Continually

UROLOGIC HISTORY

Number of urinary tract infections in the last year?_____	Any blood in the urine? YES / NO If yes, when?
Any kidney infections (pyelonephritis)? YES / NO	Do you find it hard to begin urinating? YES / NO
Any history of kidney stones? YES / NO If yes, then explain:	Did you have urinary problems in childhood? YES / NO
After emptying your bladder, do you feel like you have emptied completely? YES / NO	Have you ever been catheterized in order to pass urine? YES / NO
How many times do you urinate during the day?_____	How many times do you urinate at night after you go to sleep?_____ What time do you stop drinking fluids at night? _____ pm

BOWEL SYMPTOMS

Diarrhea YES / NO Constipation YES / NO Laxative Use YES / NO Do you have "accidents" with stool or gas?: fecal soiling YES / NO liquid stools YES / NO formed stools YES / NO flatus gas YES / NO If yes, how often do you have "accidents"?_____	Do you strain with a bowel movement? YES / NO Do you push with a finger in the vagina to assist with a bowel movement? YES / NO How often do you have a bowel movement? _____

PROLAPSE

Do you experience pressure and/or heaviness in the vagina? YES / NO

Do you feel a bulge in the vagina? YES / NO

Do you see a bulge in the vagina? YES / NO

Please list any allergies (food, medications, etc.) and your reaction to them:

Allergy	Reaction

Please list or attach a list of your current medications, dose, and how often you take them *(this includes birth control and hormone replacement meds).* Also, please include any vitamins or herbal supplements you are taking as well:

Medication	Dose	How often

Fluid Intake:

Approximately how many ounces of fluid do you drink per day (a typical glass/cup is 8 oz)? _____oz

What do you mostly drink? ☐ Water ☐ Tea ☐ Coffee ☐ Soda/soft drinks ☐ Wine/alcohol ☐ Other _____

Medical History:

Please list any and all current medical conditions you may have:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Surgical History:

Please list any past surgeries and date:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Please indicate the most recent date/result for the following procedures. If a procedure does not apply to you, select 'No'.

Procedure		Date	Result
Pap Smear	☐ Yes ☐ No	_____	
Colonoscopy	☐ Yes ☐ No	_____	

Past Obstetrical History:

How many times have you been pregnant?_____

(Please skip if no pregnancies)

Of these pregnancies, how many were…**along w/ year(s)**

vaginal deliveries	_____	Year(s):_____
cesarean deliveries	_____	Year(s):_____
full term deliveries	_____	Year(s):_____
preterm deliveries	_____	Year(s):_____
miscarriages or abortions	_____	Year(s):_____
forceps or vacuum	_____	Year(s):_____

Weight of largest baby:_____

Episiotomy: YES / NO

Large tear: YES / NO

Past Gynecological History:

What was the first day of your last menstrual period?_____

Are you sexually active? ☐ Yes ☐ No

Do you experience pain with intercourse? ☐ Yes ☐ No

Social History:

Are you? ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Who do you live with?_____

Do you work now? ☐ Yes ☐ No

What is your current or most recent job?_____

Do you exercise? ☐ Yes ☐ No

Describe your current exercise routine. _____

Do you smoke? ☐ Yes, current smoker ☐ No, former smoker ☐ No, never smoked

If yes (or former), how many cigarretes per day? ☐ 5 ☐ 10 ☐ 20 (one pack) ☐ More than 20

Would you like help to quit smoking? ☐ Yes ☐ No

How often do you drink alcohol? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Do you use any other drugs? ☐ Yes ☐ No Please list_____

Family History:

Have any of your relatives had any of the following illnesses?

Diabetes ☐ Yes ☐ No Who?_____

Stroke ☐ Yes ☐ No Who?_____

Asthma ☐ Yes ☐ No Who?_____

Migraine headaches ☐ Yes ☐ No Who?_____

Hypertension ☐ Yes ☐ No Who?_____

Heart Disease ☐ Yes ☐ No Who?_____

Kidney problems ☐ Yes ☐ No Who?_____

Mental disease ☐ Yes ☐ No Who?_____

Cancer ☐ Yes ☐ No Who and what type?_____

Please indicate whether each of the following is currently a concern for you.

General
- ☐ Yes ☐ No Excessive fatigue
- ☐ Yes ☐ No Weight loss
- ☐ Yes ☐ No Excessive thirst
- ☐ Yes ☐ No Feeling abnormally hot or cold
- ☐ Yes ☐ No Lumps or swelling

Eye, Ear, Nose & Mouth
- ☐ Yes ☐ No Hearing difficulty
- ☐ Yes ☐ No Ringing in the ear
- ☐ Yes ☐ No Change in vision
- ☐ Yes ☐ No Change in voice
- ☐ Yes ☐ No Difficulty swallowing

Breasts
- ☐ Yes ☐ No Lumps
- ☐ Yes ☐ No Tenderness
- ☐ Yes ☐ No Swelling
- ☐ Yes ☐ No Nipple discharge
- ☐ Yes ☐ No Skin changes / rash

Lungs
- ☐ Yes ☐ No Shortness of breath
- ☐ Yes ☐ No Cough
- ☐ Yes ☐ No Wheezing
- ☐ Yes ☐ No Coughing up blood

Gastrointestinal
- ☐ Yes ☐ No Poor appetite
- ☐ Yes ☐ No Frequent nausea and / or vomiting
- ☐ Yes ☐ No Heartburn
- ☐ Yes ☐ No Black, tarry stool
- ☐ Yes ☐ No Constipation
- ☐ Yes ☐ No Diarrhea
- ☐ Yes ☐ No Blood in stool

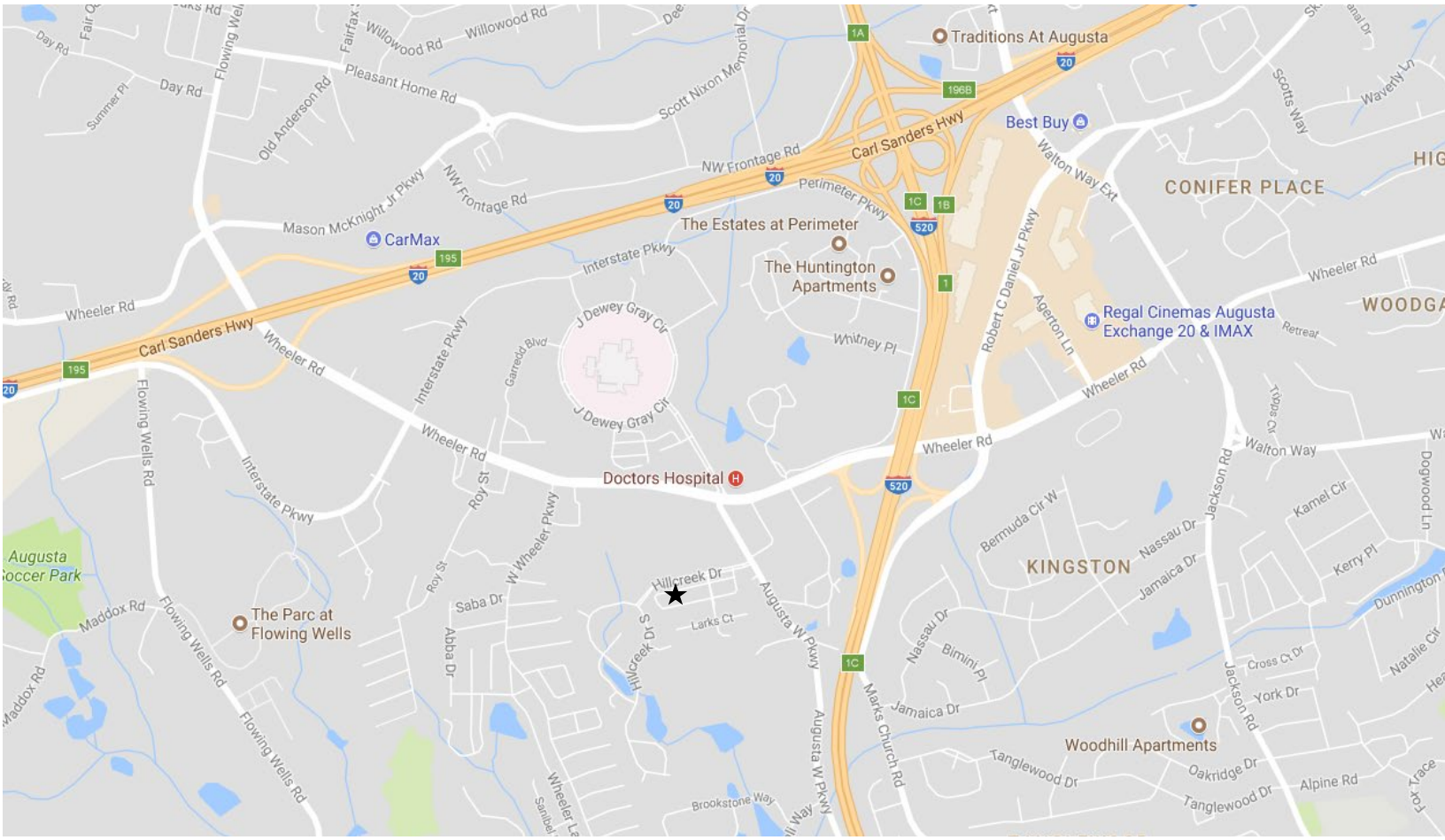
Skin
- ☐ Yes ☐ No Rashes
- ☐ Yes ☐ No Recurrent sores
- ☐ Yes ☐ No Moles that have changed in color or size
- ☐ Yes ☐ No Swollen glands
- ☐ Yes ☐ No Itching

Heart
- ☐ Yes ☐ No Chest pain
- ☐ Yes ☐ No Heart palpitations *(irregular heart beat)*
- ☐ Yes ☐ No Discomfort in chest with exercise or walking
- ☐ Yes ☐ No Difficulty breathing
- ☐ Yes ☐ No High blood pressure
- ☐ Yes ☐ No Anemia

Nervous System
- ☐ Yes ☐ No Frequent or severe headaches
- ☐ Yes ☐ No Dizziness
- ☐ Yes ☐ No Fainting *(fell out)*
- ☐ Yes ☐ No Recurrent numbness or tingling of hands / feet
- ☐ Yes ☐ No Mood swings, irritability
- ☐ Yes ☐ No Depression or anxiety

Urinary
- ☐ Yes ☐ No Pain when urinating
- ☐ Yes ☐ No Excessive urinating at night
- ☐ Yes ☐ No Bladder infections
- ☐ Yes ☐ No Leakage of urine
- ☐ Yes ☐ No Kidney stones

Gynecological
- ☐ Yes ☐ No Heavy bleeding
- ☐ Yes ☐ No Bleeding between periods
- ☐ Yes ☐ No Irregular bleeding
- ☐ Yes ☐ No Severe cramps with period
- ☐ Yes ☐ No Pelvic pain
- ☐ Yes ☐ No Sores or ulcers
- ☐ Yes ☐ No Vaginal discharge
- ☐ Yes ☐ No Foul smelling odor
- ☐ Yes ☐ No Pain after sex
- ☐ Yes ☐ No Bleeding after sex



★ 2834 Hillcreek Drive Augusta, GA 30909

- From Wheeler Rd. Turn onto Augusta West Parkway (the opposite way of Doctors Hospital)
- Take your **First Right** onto Hillcreek Drive (Just before the Regions Bank)
- Once on Hillcreek Drive make the **Third Left** into the office complex (the last one before you see houses)
- Turn left and we are the first office on the Right. A brick exterior with 3 arched windows.

We look forward to seeing you at your appointment!