Northeast Ohio
Urogynecology

Mary South, MD
3647 Medina Road
Medina, OH 44256
Phone: 234-205-2040 Fax: 234-205-2040

_____has an appointment

on_____at_____AM/PM.

To make sure your first visit goes smoothly, we ask that you complete the enclosed questionnaire to the best of your ability. Not all questions will pertain to you. **Please be aware that if the paperwork is not completed at the time of your appointment, your appointment time may be delayed.**

Please Bring the Following To Your Appointment:

□ Completed new patient questionnaire

□ Updated insurance cards

□ If required by your insurance plan, please obtain a valid referral from your Primary Care Physician (PCP), even if another physician has referred you to us. You may have this faxed directly to our office or mailed. We need this prior to your visit.
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□ Verification of your insurance company's preferred hospital system

Please arrive 10-15 minutes early to make sure all paperwork is in order.

We may need to obtain a urine specimen during your visit, so please arrive with a comfortably full bladder. Of note, we are unable to provide annual exams and general gynecology services.

Directions

Our office in Medina is located on Route 18 across the street from The First Baptist Church and Buehler's. To get to our parking lot, you will turn onto Victor Drive between our building and the US Bank Building. We are located in the Southwest Urology office. Parking is located directly in front of the building. Of note, GPS may not take you to the exact address (we have had problems with this in the past).

We look forward to meeting you. We will do our best to provide you with the highest quality of care tailored to your personal needs and concerns. Thank you so much for choosing Northeast Ohio Urogynecology.

Northeast Ohio Urogynecology Patient History Intake Form

Last Name _____ First Name _____ Age _____

Reason for Visit:

_____

_____

Allergies: _____

Medical History: Which of the following conditions are you currently being treated or have been treated for in the past? (Please Check)

□ Heart Disease / Murmur / Angina	□ Shortness of Breath	□ Eye Disorder
□ Diabetes	□ High Cholesterol	□ Asthma
□ Kidney / Bladder Problems	□ Seizures	□ High BP
□ Lung Problems / Cough	□ Psychiatric Care	□ Liver Problems
□ Blood Clot	□ Stroke	□ Headaches
□ Arthritis	□ Sinus Problems	□ Seasonal Allergies
□ Neurological Problems	□ Heartburn (Reflux)	□ Anemia
□ Tonsillitis	□ Cancer	□ Ulcers / Colitis
□ Swollen Ankles	□ Depression/Anxiety	□ Thyroid Problems

Past Surgical History:

□ Hysterectomy	Date: _____	Incision:	□ Abdominal	□ Vaginal
□ Bladder Sling	Date: _____	Type:	□ Mesh	□ Fascial/Cadaveric
□ Prolapse Surgery	Date: _____	Type:	□ Mesh	□ Non-Mesh
□ Major Abdominal	Date: _____	Reason: _____		
□ Laparoscopic Abdominal	Date: _____	Reason: _____		
□ Other	Date: _____	Reason: _____		
□ Other	Date: _____	Reason: _____		
□ Other	Date: _____	Reason: _____		
□ Other	Date: _____	Reason: _____		

OB/GYN History:

# of Pregnancies: _____ # of Vaginal Births: _____ # of Ce-Sections: _____

□ Premenopausal □ Peri-Menopausal □ Menopausal

Do you use hormone replacement?

□ Oral Contraception □ Oral HRT □ Vaginal Estrogen

Social History:

□ Alcohol	□ Drugs	□ Cigarettes
□ Single	□ Married	□ Divorced

Family History:

□ Cancer	□ Bleeding Disorders	□ Heart Disease
□ Diabetes	□ Hypertension	□ Other _____

Northeast Ohio Urogynecology Patient Medication List

Please write down all of your medications below or provide an attached list.

Prescription Medications:	Over-the Counter Medications
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Northeast Ohio Urogynecology Review of Systems

General/Constitutional

○ Appetite	○ Fatigue	○ Fever
○ Weight Change		

HEENT/Neck

○ Change in Vision	○ Hearing Loss	○ Nasal Congestion
○ Hoarseness	○ Sore Throat	

Endocrine

○ Cold Intolerance	○ Excessive Thirst	○ Excessive Urination
○ Heat Intolerance		

Respiratory

○ Chronic Cough	○ Shortness of Breath	○ Wheezing

Cardiovascular

○ Chest Pain	○ Leg Swelling	○ Palpitations
○ Varicose Veins		

Gastrointestinal

○ Abdominal Pain	○ Bloating	○ Blood in Stool
○ Change in Bowel Habits	○ Heartburn	○ Incontinence of Stool
○ Nausea	○ Vomiting	

Hematology

○ Anemia	○ Easy Bleeding	○ Easy Bruising

Women Only

○ Vaginal Dryness	○ Low Libido	○ Pain with Sex
○ Heavy Periods	○ Hot Flashes	○ Irregular Periods

Genitourinary

○ Blood in Urine	○ Burning on Urination	○ Urinary Tract Infections
○ Urinary Incontinence	○ Vaginal Discharge	○ Vaginal Pressure/Bulge

Musculoskeletal

○ Back Pain	○ Joint Pain	○ Joint Stiffness
○ Muscle Pain	○ Tingling/Numbness	

Neurologic

○ Confusion	○ Dizziness	○ Headache
○ Seizure		

Mental Health

○ Anxiety	○ Depression	○ Sleep Disturbances

Pelvic Floor Symptom Survey

Instructions: Please answer all of the questions in the following survey. Answer these by circling the appropriate number. While answering these questions, please consider your symptoms over the last 3 months.

Symptoms Present = Yes: 1 = Not at all, 2 = Somewhat, 3 = Moderately, 4 = Quite a bit
Not Present = No: 0 = Not Present

Pelvic Organ Prolapse Symptoms:

Do You….	No	Yes
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Every have to push on the vagina or around the rectum to have to complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1 2 3 4

Bowel Symptoms:

Do You….	No	Yes
1. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
2. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
3. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
4. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
5. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
6. Usually have pain when you pass your stool?	0	1 2 3 4
7. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
8. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1 2 3 4

Urinary Symptoms:

Do You….	No	Yes
1. Usually experience frequent urination?	0	1 2 3 4
2. Usually experience urine leakage associated with it feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	1 2 3 4
3. Usually experience urine leakage related to coughing, sneezing, or laughing?	0	1 2 3 4
4. Usually experience small amounts of urine leakage (that is, drops)?	0	1 2 3 4
5. Usually experience difficulty emptying your bladder?	0	1 2 3 4
6. Usually experience pain or discomfort in the lower abdomen or genital region?	0	1 2 3 4

Northeast Ohio Urogynecology Sexual Function Questionnaire

Are you currently sexually active?

○ **No.** Please Circle Reason:

I am not able I have too much pain I have no desire

I do not have a partner My partner is not able

○ **Yes.** Proceed with the next 4 questions:

1. Do you feel pain during sexual intercourse?
○ Always ○ Usually ○ Sometimes ○ Seldom ○ Never

2. Are you incontinent of urine (leak urine) with sexual activity?
○ Always ○ Usually ○ Sometimes ○ Seldom ○ Never

3. Does fear of incontinence (either stool or urine) restrict your sexual activity?
○ Always ○ Usually ○ Sometimes ○ Seldom ○ Never

4. Do you avoid sexual intercourse because of bulging of the vagina (either bladder, rectum, or vagina falling out?)
○ Always ○ Usually ○ Sometimes ○ Seldom ○ Never

Northeast Ohio Urogynecology Patient Demographic Form:

Patient Information

Last Name:	First Name:	Middle Initial:
Date of Birth:	Social Security:	Gender: ○ Male ○ Female
Marital Status:	○ Married ○ Single	Language: ○ English ○ Spanish
Race: ○ American Indian ○ Asian ○ Hispanic	○ Native Hawaiian	○ African American ○ Other
Home Address:	Apt #:	City/State/Zip:
Home Phone:	Work Phone:	Cell Phone:
Email Address:		
Sign up for Dr. South's Educational Website?	○ Yes	○ No

Responsible Party (Guarantor) Information

Relationship to Patient:	○ Self ○ Spouse	○ Parent ○ Other
Last Name:	First Name:	Middle Initial:
Date of Birth:	Social Security:	
Home Address:	Apt #:	City/State/Zip:
Home Phone:	Work Phone:	Cell Phone:

Emergency Contact

Last Name:	First Name:	Relationship to Patient:
Address:	Apt #:	City/State/Zip:
Home Phone:	Work Phone:	Cell Phone:

Pharmacy

Name of Pharmacy:
Address:
Phone Number:

Referring Physician

Name:	Phone Number: