Mary South, MD
468 E. Market Street, Suite D
Akron, OH 44304
Phone: 234-205-2040 Fax: 866-614-7263

____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

If you are coming south on Route 8, get off at Perkins exit, go straight, through two lights, until you get to East Market Street then take a left-hand turn. Building is beige with a teal band around the top and is located on your right-hand side just as you cross over the highway. If you are coming north on Route 8, get off at the Caroll St-Buchtel Avenue exit. Follow Fountain Street until you get to East Market and the building is on your right-hand side. Free parking is available in the surface lot behind our building.

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.

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Urogynecology

Last Name ____________________________ First Name __________________________ Age______

Date of Birth _________ Race _________

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)?

□ Anemia	□ GERD/reflux	□ IBD (UC/Crohn's)
□ Aortic stenosis	□ Glaucoma	□ Irritable Bowel Syndrome
□ Arthritis	□ Headaches /Migraines	□ Kidney Disease
□ Asthma	□ High blood pressure	□ Multiple Sclerosis
□ Blood clotting disorder	□ High cholesterol	□ Other lung disease
□ Cancer:______________	□ History of Blood Clot	□ Other neurologic disease
□ Congestive Heart Failure	□ History of Heart Attack	□ Psychiatric care
□ COPD	□ History of Stroke	□ Seizures
□ Depression / Anxiety	□ Hyperthyroid/Hypothyroid	□ Sleep Apnea
□ Diabetes	□ Impaired liver function / Hepatitis	

Past Surgical History:

□ Hysterectomy	Date:____________	Incision: □ Abdominal □ Vaginal
□ Bladder Sling	Date:____________	
□ Prolapse Surgery	Date:____________	
□ Major Abdominal	Date:____________	Reason: ________________________________
□ Laparoscopic Abdominal	Date:____________	Reason: ________________________________
□ Knee replacement	Date:____________	
□ Appendectomy	Date:____________	
□ Cholecystectomy	Date:____________	
□ Other	Date:____________	Reason: ________________________________

OB/GYN History:

# of pregnancies:_________	# of vaginal births:_________	# of C-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_________________________

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Medication List

Name___________________________

Date___________________________

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

Prescription Medications

Name	Dose

Over-the-Counter Medications

Name	Dose

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Review of Systems

Name_____________________________

Date______________________________

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

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Name______________________________

Pelvic Floor Symptom Survey

Date______________________________

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**.

Not Present = NO: 0 = not present

If Present = YES and how bothersome are symptoms?
1 = not at all, 2 = somewhat, 3 = moderately, 4 = quite a bit

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. Ever have to push on the vagina or around the rectum to have or 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			
7. Feel you need to strain too hard to have a bowel movement?	0	1	2	3	4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1	2	3	4
9. Usually lose stool beyond your control if your stool is well formed?	0	1	2	3	4
10. Usually lose stool beyond your control if your stool is loose?	0	1	2	3	4
11. Usually lose gas from the rectum beyond your control?	0	1	2	3	4
12. Usually have pain when you pass your stool?	0	1	2	3	4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1	2	3	4
14. 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			
15. Usually experience frequent urination?	0	1	2	3	4
16. 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
17. Usually experience urine leakage related to coughing, sneezing, or laughing?	0	1	2	3	4
18. Usually experience small amounts of urine leakage (that is, drops)?	0	1	2	3	4
19. Usually experience difficulty emptying your bladder?	0	1	2	3	4
20. Usually experience pain or discomfort in the lower abdomen or genital region?	0	1	2	3	4

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Sexual Function Questionnaire

Name______________________________

Date______________________________

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 next 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 you 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

Patient Demographic Form

Last Name:	First Name:	Middle Initial:
Date of Birth:	Social Security:	Gender: ○ Male ○ Female
Marital Status: ○ Married ○ Single	Language: ○ English ○ Spanish ○ Nepalese ○ Arabic ○ Other	
Race: ○ White, Non-Hispanic ○ Asian ○ Hispanic ○ 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:
Home Address: Apt #: City/State/Zip:		
Home Phone:	Work Phone:	Cell Phone:

Pharmacy

Name of Pharmacy:
Address:
Phone Number:

Referring Physician

Name:	Phone Number: