UNC HEALTH CARE
WOMEN'S CARE

UNC Urogynecology and Reconstructive Pelvic Surgery
Division of Female Pelvic Medicine and Reconstructive Surgery (FPMRS)

We look forward to your upcoming visit with us. Our goal is to provide you with outstanding care.

Please arrive 15 minutes prior to your appointment with this paperwork completed. These forms will be collected at check-in. If you arrive past your appointment time, we may need to reschedule your visit.

Please sign up for My UNC Chart. My UNC Chart is a safe, easy, and secure way to access your health information when it's convenient for you. My UNC Chart allows you to manage your health, send messages to your provider's office, view your test results, schedule and manage appointments, and request prescription refills securely and conveniently from your computer or mobile device. To sign up for an account, go to https://myuncchart.org.

UNC Urogynecology Office Locations

UNC Rex Urogynecology Clinic

4325 Lake Boone Trail, Suite 315
Raleigh, NC 27607

984-974-0496 | **Appointments**

984-974-0499 | **Fax**

UNC Hillsborough Urogynecology Clinic

460 Waterstone Drive, 3rd floor
Hillsborough, NC 27278

984-215-3510 | **Appointments**

984-215-3512 | **Fax**

Additional information about our practice and our providers can be found at:

www.UNCurogyn.org

MEET OUR TEAM

At **UNC Urogynecology and Reconstructive Pelvic Surgery**, we believe that team-based medicine provides patients with outstanding care and greater access to resources. Our multi-disciplinary team consists of medical assistants, nurses, nurse practitioners, physician assistants, and physicians at various levels of training.

Members of your care team may include:

Residents: After completion of medical school, an individual becomes a "Doctor." In order to develop the practical skills needed to become an independent, board-certified physician, these Doctors go through a training process called "residency". UNC has one of the nation's best OB-GYN residency programs. Residents enhance our ability to care for women with pelvic floor disorders, and they are fully supervised.

Fellows: When physicians choose to focus specifically in our field, Female Pelvic Medicine and Reconstructive Surgery (FPRMS) also known as Urogynecology, they complete a fellowship. Fellows are licensed physicians who are supervised by and work alongside the attending physicians. Our Fellows at UNC Urogynecology focus on advanced office practice, surgical training, and research in order to provide cutting-edge health care services to women with pelvic floor disorders.

Nurse Practitioners: Nurse Practitioners (NPs) complete a master's or doctoral graduate degree program and have advanced clinical training beyond their initial registered nurse preparation. Similar to physicians, NPs pass a national board certification exam and are licensed in their state. NPs are able to independently provide a full range of office-based evaluations and treatment options; however, they do not perform surgery.

Attending Physicians: Our attending physicians have completed specialized training and are independent, licensed, board-certified Female Pelvic Medicine and Reconstructive Surgery doctors, who supervise the entire medical team.

UNC Urogynecology and Reconstructive Pelvic Surgery is committed to providing quality care for women with pelvic floor disorders. We follow the University of North Carolina's anti-discrimination statement and do not discriminate based on age, race, religion or gender.

We are a multidisciplinary team serving not only the Raleigh/Durham/Chapel Hill area, but also the entire state of North Carolina. We provide comprehensive care with providers who have advanced specialty training in Urogynecology and Reconstructive Pelvic Surgery. When you receive care at the UNC Urogynecology, you will have a team that may include attending physicians, fellows, nurse practitioners, residents, nurses, and medical students, all of whom work as a team to provide outstanding care. All care is ultimately supervised by an attending physician. We have providers of all ages, races, religions and genders, and given our team approach, you may not see the same provider at all of your visits. This allows us to focus on providing you with high-quality, compassionate medical care.

We look forward to meeting you and working with you.

Patient Information

Patient Name_____

Date of Birth_____Age_____

Race/Ethnicity_____

Pharmacy

Name_____

Address_____

City_____State_____Zip_____

Phone_____

Have you been seen in our practice before? ☐ Yes ☐ No

Who completed this form? ☐ Self ☐ Someone else

Referring Physician

Name_____

Address_____

City_____State_____Zip_____

Phone_____

Primary Care Physician

Name_____

Address_____

City_____State_____Zip_____

Phone_____

Today's Visit

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

_____

_____

What are your expectations for today's visit?_____

_____

Urinary Leakage

Do you leak urine when you cough, sneeze, or laugh? ☐ Yes ☐ No, Prior treatment?_____

Do you leak urine with urge or on the way to the bathroom? ☐ Yes ☐ No, Prior treatment?_____

Do you leak urine when: ☐ Walking ☐ Exercising ☐ Lifting ☐ Going from sitting to standing ☐ Intercourse ☐ With Urgency

How often do you leak urine? ☐ _____times per day ☐ _____times per week ☐ _____ times per month

Do you use a pad for urine leakage? ☐ Yes ☐ No How many per day?_____ ☐ Mini pad ☐ Pad ☐ Adult Diaper

Are you bothered by your urinary leakage? ☐ Yes ☐ No

Voiding Symptoms

How many times do you urinate during the day?_____ How many times do you get up during the night to urinate?_____

Do you ever have to push up on a bulge in the vaginal area to start or complete urination? ☐ Yes ☐ No

After emptying your bladder do you have the feeling that you have not finished? ☐ Yes ☐ No

Urinary Tract Infections / Kidney Stones

Number of urinary tract infections in the last year: _____ Have you ever had a kidney infection (pyelonephritis)? ☐ Yes ☐ No

Have you had blood in your urine? ☐ Yes ☐ No If yes, could you see the blood in your urine? ☐ Yes ☐ No

Have you ever had kidney stones? ☐ Yes ☐ No

Pelvic Organ Prolapse Symptoms

Do you feel a bulge in the vagina? ☐ Yes ☐ No Do you see a bulge coming out of the vagina? ☐ Yes ☐ No

Is it bothersome? ☐ Yes ☐ No Have you had treatment for this bulge? ☐ Yes ☐ No; If yes what: _____

Bowel Symptoms

How often do you have a bowel movement? ☐ Every day ☐ ____times per day ☐ ____times per week ☐ Every ____weeks

What is the consistency of your stools? ☐ Hard ☐ Soft ☐ Loose

What is your bowel regimen? ☐ Diet ☐ Fiber ☐ Stool Softener ☐ Miralax ☐ Other _____

Do you have accidental bowel leakage (ABL) and leak solid or liquid stool? ☐ Yes ☐ No How often:_____

Do you feel that you need to strain too hard to have a bowel movement? ☐ Yes ☐ No

Do you have to push on the vagina or around the rectum to have or complete a bowel movement? ☐ Yes ☐ No

Do you feel that you have not completely emptied your bowels at the end of a bowel movement? ☐ Yes ☐ No

Do you have a strong sense of urgency and have to rush to the bathroom to have a bowel movement? ☐ Yes ☐ No

Past Obstetrical and Gynecologic History

How many times have you been pregnant?_____ Vaginal deliveries:_____ Forceps/vacuum deliveries:_____ C-sections:_____

Have you gone through menopause? ☐ Yes ☐ No If no, when was your last menstrual period?_____

Are you sexually active? ☐ Yes ☐ No Do you have pain with intercourse? ☐ Yes ☐ No; If yes, describe:_____

What do you use for contraception? ☐ N/A ☐ Pills ☐ IUD ☐ Diaphragm ☐ Condoms ☐ Tubes Tied ☐ Vasectomy

Last Pap Test: Date_____ Results_____ Any history of abnormal pap smears? ☐ Yes ☐ No

Last Colonoscopy: Date_____ Results_____

Social History

Are you? ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Unmarried with partner

Who do you live with?_____

Are you currently working? ☐ Yes ☐ No What is your current job?_____

Do you exercise? ☐ Yes ☐ No If yes, describe_____

Have you ever been emotionally, physically, or sexually abused? ☐ Yes ☐ No; If yes, when?_____

Please indicate if any of the following are a NEW concern for you

☐ Yes ☐ No Unexplained weight loss

☐ Yes ☐ No Chest pain/chest discomfort with exercise

☐ Yes ☐ No Heart palpitations *(irregular heart beat)*

☐ Yes ☐ No Shortness of breath

☐ Yes ☐ No Heartburn

☐ Yes ☐ No Joint and/or back pain

☐ Yes ☐ No Skin rashes or lesions

☐ Yes ☐ No Dizziness

☐ Yes ☐ No Depression or Anxiety

☐ Yes ☐ No Thoughts of harming yourself or others

☐ Yes ☐ No Easy bruising

☐ Yes ☐ No Blood clots in your legs or lungs

Medical History (*List **all** current medical conditions*)

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

Surgical History *(List **all** past surgeries and the dates of those surgeries)*

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

(List current medications, dose, and how often you take them. Include birth control, hormones, vitamins and supplements.)

Medication	Dose	Frequency *(schedule)*

Allergy *(List allergies to medication, latex and food)*	Reaction

Do you smoke? ☐ Yes ☐ No If yes, how many per day?_____ Would you like help to quit smoking? ☐ Yes ☐ No

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

Do you use any illegal drugs? ☐ Yes ☐ No If yes, please list:_____

Family History Have any of your relatives had any of the following medical conditions?

Bleeding disorder ☐ Yes ☐ No Who?_____

Clotting disorder ☐ Yes ☐ No Who?_____
(e.g. DVT – deep venous thrombosis, PE – pulmonary embolism)

Colon Cancer ☐ Yes ☐ No Who?_____

Gynecologic Cancer ☐ Yes ☐ No Who?_____
(e.g. uterine/endometrial, ovarian, cervical)

Bladder or Kidney Cancer ☐ Yes ☐ No Who?_____

Breast Cancer ☐ Yes ☐ No Who?_____