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 _____

Release of Information Authorization

Please mark below for release of information concerning your healthcare and/or financial arrangements:

Release information ONLY to me: ___ Yes ____ No
Release of Information to Spouse: ___ Yes ____ No
Spouse's Name: _____

Release of Information to Other Individual: ___ Yes ____ No
Name & Relationship: _____
Phone #: _____

Preferences

I prefer to be contacted in the following manner:
Phone#: ( ) _____
☐ Leave message with detailed information.
☐ Leave message with contact number only.
☐ Do not leave message.

I am fully aware my health information will be transmitted by electronic transmission, fax transmittal, internet or e-mail.

Signature _____ _____
Patient/Guardian Date

Consent to receive text messages about appointment reminders:
Patients in our practice

I _____ consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number to receive appointment reminders. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing.

- The **CELL PHONE NUMBER** that I authorize to receive
  - ☐ TEXT Reminders
    - Is: (_____) _____-_____

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details)

North Dallas Urogynecology
Female Pelvic Medicine and Reconstructive Surgery

MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Age:_____ Date: _____

Primary Care Physician:	Gynecologist:
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Phone: _____	Phone: _____

Name of previous Urologist (if applicable): _____

Whom may we thank for referring you to us? _____

Please describe in your own words the nature of your gynecologic problems':

_____

_____

When did you first become aware of the problem? _____

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: Height: _____ Weight: _____

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	B a c k 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?*_____

…at what age?

What type of incision? Abdominal ____ *Vaginal*____ *Laparoscopic*____

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 ☐ vape ☐ 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 Children _____

Number of miscarriages _____ Number of abortions _____

Date of Last Menstrual Period:_____

Last Pap Smear Date: Normal? Y N

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

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
Difficulty Remembering

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				
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				
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