Center for

**Urogynecology**

& Pelvic Reconstructive Surgery

**Fareesa Khan, M.D.**

**(PHONE) 314-270-9880**

**(FAX) 888-971-4069**

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| --- | --- | --- |
| **South County** | **West County** | **Farmington** |
| **10004 Kennerly Rd** | **226 S Woods Mill Rd** | **1101 W Liberty St** |
| **Suite 255A** | **Suite 60W** | **Suite 2050** |
| **St Louis, MO 63128** | **Chesterfield, MO 63017** | **Farmington, MO 63640** |

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| --- |
| **Please Fax or Mail paperwork back to SOUTH COUNTY LOCATION** |

***Welcome to our practice!***

Your appointment is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ @ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

We are very excited to introduce you to our practice. At the Center for Urogynecology and Pelvic Reconstructive Surgery, we hope to educate, inform, and help you understand the pelvic floor issues you may be experiencing. We have included some information below to prepare you for your first visit. It is important that you read this information as soon as you receive it so you are prepared for your visit and we can care for you efficiently.

Upon checking in, we will request the following information:

* Insurance card, photo ID, and applicable co-payments
* Physician referral, if required by your insurance company
* Name and phone number of your referring physician and a pharmacy of your choice
* Completed health history form(s)
* Copies of any applicable past medical records
* Current medication list

**Please arrive for your visit with a comfortably full bladder**. We may need to test your urine depending on the reason for your visit. You will be in a private exam room where a medical assistant will take your blood pressure, height, and weight. You will then be asked to undress from the waist down.

After the medical interview, the doctor will ask your permission to proceed with a gynecologic exam. We hope to keep you as comfortable as possible during your visit. Following the examination, the doctor will discuss her findings as well as any recommendations she may have. Please let us know if you have family members in the waiting room that you would like to join you for the discussion.

We are devoted to providing you with the highest quality care in Female Pelvic Medicine and Reconstructive Surgery. Our goal is for you to leave our office feeling empowered to make the best possible decision regarding your health in the future.

**Patient Data Sheet**

Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRACTICE TO PATIENT CONFIRMING APPTS:

* Email reminders and messaging Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* SMS text reminders and messaging Cell Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Voicemail reminders and messaging Home Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information**

Name (Last, First, Middle)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Street, city, state, zip)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who can we speak to regarding your medical care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy Information**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information** (copies of card will be required)

Primary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective date\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of policy holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if different from above) Insured party’s:

Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective date\_\_\_\_\_\_\_\_\_\_\_\_\_

(if different from above) Insured party’s:

Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assignment of insurance information and benefits/release of medical information: I hereby authorize Fareesa Khan LLC to administer/perform any medical services deemed necessary, and authorize release of information need to secure payment. I authorize that all benefits paid by my insurance company, be paid to Fareesa Khan LLC. I understand that I am financially responsible for all charges incurred that are not covered in full by my insurance company. In addition, I hereby authorize the release of all applicable medical information, including and without limitation copies of all records and test results to the designated attending, referring, and/or follow up physician, as well as other such health care practitioners or organizations providing subsequent monitoring of care or treatment in connection with the care provided by this facility.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications List**

**Past Medical History**

Osteoporosis \_\_\_\_Yes \_\_\_\_ No Anxiety \_\_\_\_Yes \_\_\_\_ No

High Blood Pressure \_\_\_\_Yes \_\_\_\_ No Depression \_\_\_\_Yes \_\_\_\_ No

Stroke \_\_\_\_Yes \_\_\_\_ No Bipolar \_\_\_\_Yes \_\_\_\_ No

Heart Disease/ Attack \_\_\_\_Yes \_\_\_\_ No Mental Illness \_\_\_\_Yes \_\_\_\_ No

Kidney Stones \_\_\_\_Yes \_\_\_\_ No Dementia (Alzheimer’s) \_\_\_\_Yes \_\_\_\_ No

Thyroid Disease \_\_\_\_Yes \_\_\_\_ No Ulcers \_\_\_\_Yes \_\_\_\_ No

Seizures \_\_\_\_Yes \_\_\_\_ No Liver Disease \_\_\_\_Yes \_\_\_\_ No

Bleeding Disorder \_\_\_\_Yes \_\_\_\_ No High Cholesterol \_\_\_\_Yes \_\_\_\_ No

Tuberculosis \_\_\_\_Yes \_\_\_\_ No Diabetes \_\_\_\_Yes \_\_\_\_ No

Rheumatic Fever \_\_\_\_Yes \_\_\_\_ No IBS \_\_\_\_Yes \_\_\_\_ No

Pneumonia \_\_\_\_Yes \_\_\_\_ No Cancer \_\_\_\_Yes \_\_\_\_ No

Asthma \_\_\_\_Yes \_\_\_\_ No type\_\_\_\_\_\_\_\_\_\_\_\_

Emphysema / COPD \_\_\_\_Yes \_\_\_\_ No STD \_\_\_\_Yes \_\_\_\_ No

type \_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Name Strength/ Number of Number of times

(please include over the counter medications) Dosage (mg) pills per dose taken per day

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

10. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

**Allergies**

Drug Reaction

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Latex Allergy? \_\_\_Yes \_\_\_No Betadine Allergy \_\_\_Yes \_\_\_No

**Surgical History**

Surgery Date (year)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

Do you have a family history of breast cancer? \_\_\_Yes \_\_\_No

Do you have a family history of gynecological cancer? \_\_\_Yes \_\_\_No

If yes, please list their relation to you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Alcohol use \_\_\_Never \_\_\_Rarely \_\_\_Moderate \_\_\_Daily \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other

Drug use \_\_\_Yes \_\_\_No Type / Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco Use \_\_\_Never \_\_\_Previously, but quit (list year\_\_\_) \_\_\_Current (packs per day \_\_\_)

Marital Status \_\_\_Single \_\_\_Married \_\_\_Separated \_\_\_Divorced \_\_\_Widowed

**Preventative** **Care**

Treatment Year Location (hospital)

Pap Smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mammogram \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bone density \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colonoscopy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Obstetrical and Gynecological History**

Number of: Pregnancies\_\_\_\_\_ children born\_\_\_\_\_ Vaginal Deliveries\_\_\_\_\_ Cesarean Sections\_\_\_\_\_ Miscarriages\_\_\_\_\_ Weight of largest Infant delivered vaginally \_\_\_\_\_\_\_\_\_\_

During delivery, did you experience: \_\_\_Tear in rectum \_\_\_Forceps used \_\_\_ Vacuum assisted delivery

Have you had a Hysterectomy? \_\_\_Yes \_\_\_No If yes: \_\_\_total \_\_\_partial \_\_\_vaginal \_\_\_abdominal

Date of last menstrual \_\_\_\_\_\_\_\_\_\_\_\_\_ Method of birth control \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you sexually Active? \_\_\_Yes \_\_\_No If yes, how long have you been with your current partner? \_\_\_\_\_\_\_\_\_\_