231 Northern Boulevard • Suite 1 • South Abington Township, PA 18411 • 570.344.9997

Dr. Barbara
PLUCKNETT

Name:_____ DOB:____/____/_____ Age: _____
Address:_____City: _____ State: _____ Zip: _____
Home Phone: _____Work Phone: _____ Cell Phone: _____

Reason for your visit today: _____
Who referred you to our practice? _____

PAST MEDICAL HISTORY: Have you ever had or do you now have any of the following medical conditions?

- ☐ Heart Disease
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Respiratory problems
- ☐ Asthma
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ High Blood Pressure
- ☐ Phlebitis/Blood Clots
- ☐ Bleeding Disorders
- ☐ Thyroid Problems
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Seizure Disorders
- ☐ Gallbladder Disease
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Depression
- ☐ Anxiety
- ☐ Esophageal Reflux
- ☐ Diverticulitis
- ☐ Colitis
- ☐ High Cholesterol
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Cancer/Type:_____
- ☐ Migraines:_____
- ☐ Other:_____

ALLERGIES/REACTIONS, including any LATEX allergies:

MEDICATIONS: Please list ALL medications, supplements, and herbs you are currently taking; including hormones:

☐ **I give my permission to upload my medication history from my pharmacy:** _____

PAST SURGICAL HISTORY: Include any and all surgeries from birth to present time.

YEAR	TYPE OF SURGERY	COMPLICATIONS

PREGNANCY HISTORY:

Number of pregnancies: _____ Number of miscarriages: _____
Number of living children: _____ Number of terminations: _____

DATE	TYPE OF DELIVERY	SEX	WEIGHT	COMPLICATIONS

GYNECOLOGY HISTORY:

- First day of your last period: _____
- Age with your very first period: _____
- When NOT on hormonal control:
  How frequently do you have a period? _____
  Amount of days you bleed: _____
- Age with first intercourse: _____
- Number of partners/lifetime? _____
- History of Sexually Transmitted Infections? _____ What type? _____
- What do you use to prevent pregnancy? _____
- If Postmenopausal, what year did you stop having your periods? _____
- Any history of abnormal Paps? _____
  When? _____
  Diagnosis: _____
- Cervical surgery? _____
  Colposcopy: _____
  LEEP/Cyro: _____

- Last Pap Smear: _____
- Last Mammogram: _____
- Last Bone Scan: _____
- Last Colonoscopy: _____

VACCINATIONS:
- Last Influenza Vaccination: _____
- Last Pneumovax Injection: _____
- Did you recieve HPV vaccine?: _____

Do you experience any of the following?
- ☐ Bleeding between period?
- ☐ Heavy periods - changing pad or tampon every hour?
- ☐ Painful periods?
- ☐ Bleeding after intercourse?
- ☐ Pain with intercourse?
- ☐ Prolapse (Falling of pelvic organs)?

Have you ever taken hormone replacement in the past?
- What: _____
- When: _____
- For how many years: _____
- Have you ever had bleeding after menopause? _____
- If so, when: _____

SOCIAL HISTORY:
- Do you smoke cigarettes? _____
  If yes, how many per day? _____
  For how many years? _____
- Do you drink alcohol? _____
  If yes, how frequently?
  - ☐ Daily
  - ☐ Weekends
  - ☐ Socially
- Do you use street/illegal drugs? _____
  If yes, what kind? _____
  _____
  How often? _____

FAMILY HISTORY:
List ANY family members (Grandparents/Parents/ Siblings/Children) that have the following conditions.
- Heart Disease: _____
- Stroke: _____
- Bleeding Disorder: _____
- High Blood Pressure: _____
- Kidney Disease: _____
- Diabetes: _____
- Osteoporosis: _____
- Other: _____
- Cancer (What type?): _____
  _____

Reviewed by: _____ **Date:** _____

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Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email Address: _____
SSN: _____ Marital Status: _____

Primary Care Physician: _____ Phone: _____
Pharmacy: _____ Phone: _____

Occupation: _____ Employer: _____
Spouse's Name: _____ Employer: _____

Emergency Contact: _____
Relationship: _____ Phone: _____

Assignment and Release

I authorize the release of medical information to process claims for serviced rendered, and I also authorize the payment of medical benefits directly to Dr. Barbara Plucknett.

_____ _____
Signature of Insurer/Guardian Date

Medicare Insurance Agreement

I authorize the holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration of its intermediaries or carriers any kind of information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself of to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____
Signature of Insurer/Guardian Date

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VOIDING DIARY

This paperwork MUST be completed prior to your appointment. If not, your appointment will need to be rescheduled. If you have any questions, please call our office.

This chart is a record of your voiding (urination and leakage incontinence) of urine. Please complete this according to the following instructions from our office. Choose a 24 hour period to keep this record when you can conveniently measure every voiding and begin your record with first voiding upon arising as in the sample below.

EXAMPLE:

Column #1 TIME	Column #2 VOIDED	Column #3 LEAK	Column #4 URGE PRESENT	Column #5 ACTIVITY	Column #6 AMOUNT/TYPE INTAKE
6:45 AM	550 CC			awaking	
7:00 AM		2	YES	turned on water	2 cups coffee 6 oz orange juice
5:00 PM	120 CC				1 cup tea

- **Column #1 TIME:**
  Record time of all voids, leakage, intake of liquids.

- **Column #2 VOIDED:**
  Measure all intake and output in cc's or oz's.

- **Column #3 LEAK:**
  Estimate the amount of leakage according to the following scale:
  1 = damp, few drops only
  2 = wet underwear or pad
  3 = soaked or emptied pad

- **Column #4 URGE PRESENT:**
  If the urge to urinate was accompanied by the urine leakage, write YES. If you felt no urge when the leakage occurred, write NO.

- **Column #5 ACTIVITY:**
  Describe activity you were performing at the time of leakage. If you were not actively doing anything, record whether you were sitting, standing, or lying down.

- **Column #6 AMOUNT/TYPE INTAKE:**
  Record the amount and type of all liquid intake using cc's or oz's (1 cup = 8 oz = 240 cc).

Patient's Name _____

Date of Birth _____

VOIDING DIARY/UROLOG

TIME	VOIDED	LEAK	URGE PRESENT	ACTIVITY	AMOUNT/TYPE INTAKE

Name: _____ **Date:** _____

INSTRUCTIONS TO PATIENT
Please check the ( ) if your answer is "YES"

1. **Have you had treatment for urinary tract disease such as:**
   - stones ( )
   - kidney disease ( )
   - infections ( )
   - tumors ( )
   - injuries ( )
2. **Have you ever had:**
   - paralysis ( )
   - polio ( )
   - multiple sclerosis ( )
   - stroke ( )
   - back pain ( )
   - syphilis ( )
   - diabetes ( )
   - pernicious anemia ( )
3. **Have you had an operation on your:**
   - spine ( )
   - brain ( )
   - bladder ( )
4. **Have you had a bladder infection during the last year? ( )**
5. **If yes, did it occur more than twice during the last year? ( )**
6. **Did the bladder infection follow intercourse at any time? ( )**
7. **Is your urine ever bloody? ( )**
8. **Have you ever been treated by urethral dilatation? ( )**
9. **If yes, when?**_____
   How many times?_____
10. **Did urethral dilatation help you? ( )**
11. **Did you have trouble holding urine as a child? ( )**
12. **As a child, did you wet the bed? ( )**
13. **If yes, at what age did you stop?**
14. **Do you wet the bed now? ( )**
15. **What is the volume of urine you usually pass?**
    - large ( )
    - medium ( )
    - small ( )
    - very small ( )
16. **Do you notice any dribbling of urine when you stand after passing urine? ( )**
17. **Do you lose urine by spurts during severe:**
    - coughing ( )
    - sneezing ( )
    - vomiting ( )
18. **If yes, in which positions does it occur?**
    - standing ( )
    - sitting ( )
    - laying down ( )
19. **Do you lose urine without coughing, sneezing, or vomiting? ( )**

20. If yes, when does it occur?

- walking ( )
- running ( )
- straining ( )
- lying down ( )
- any change of position ( )
- after intercourse ( )
- during intercourse ( )

21. When you are passing urine, can you usually stop the flow? ( )

22. Did your urine difficultly start during:

- pregnancy ( )
- after delivery of an infant ( )

23. Did it follow an operation? ( )

24. If yes, check the type of operations:

- Hysterectomy (removal of womb), through the vagina
- Removal of a tumor through the abdomin
- Vaginal repair operation
- Suspension of the uterus or bladder
- Cesarean section
- Other _____

25. Did it follow X-RAY treatment? ( )

26. If your menstrual periods have stopped, did menopause make your condition worse? ( )

27. Do you lose control and pass a large amount of urine when you:

- cough ( )
- sneeze ( )
- lift ( )
- strain ( )
- vomit ( )
- after intercourse ( )
- during intercourse ( )

28. Do you have difficulty holding urine if you suddenly stand up after sitting or lying down? ( )

29. Do you find it necessary to wear protection because you get wet from the urine you lose? ( )

30. If yes, at what age did you start using this protection?

31. When do you wear protection?

- occasionally ( )
- all the time ( )
- only during the day ( )
- only at night ( )

32. Is your urinary problem bad enough that you would request surgery to fix it? ( )

33. List all medications you are now taking and duration of use of each medication

Medication	Dose	Direction Of Use

34. When you lose your urine accidentally, are you ever unaware that it is passing? ( )

35. Do you have to hurry to the bathroom or can you take your time?

- Hurry ( )
- Take time ( )

36. Can you overcome the uncomfortably strong need to pass urine?

- Usually ( )
- Occasionally ( )
- Rarely ( )

37. Can you overcome the uncomfortably strong need to pass urine with a full bladder? ( )

38. Do you have an uncomfortably strong need to pass urine without a full bladder? ( )

39. How many times do you void during the night after going to bed? _____

40. **How many times do you void during the first hour after going to bed?_____**
41. **Does an uncomfortably strong need to pass urine wake you up? ( )**
42. **Are you usually awake and simply pass urine while up? ( )**
43. **After passing urine, can you usually go back to sleep? ( )**
44. **How much fluid do you usually drink before going to bed?_____** cups.
45. **Do you have discomfort in the area above or the side of your bladder? ( )**
46. **Do you have pain while you pass your urine? ( )**
47. **Is it painful during the entire time you pass urine? ( )**
48. **Is it painful only at the end of passing urine? ( )**
49. **Do you always feel that your bladder is empty after passing urine? ( )**
50. **Do you usually have painful passing of urine after intercourse? ( )**
51. **Do you need to pass urine more frequently after intercrouse? ( )**
52. **Does your bladder discomfort stop completely after passing urine? ( )**
53. **How often do you pass urine during the day?** Every _____hours.
54. **Do you need to pass urine more frequently while riding in a car? ( )**
55. **Are you ever suddenly aware that you are losing or are about to lose control of your urine? ( )**
56. **How often does this occur?** _____/Day _____ /Week
57. **Does the sound, the sight, or the feel of running water cause you to lose urine? ( )**
58. **Is your clothing slightly:**
    - damp ( )
    - wet ( )
    - soaking wet ( )
    - leave puddles on floor ( )
59. **Is your loss of urine a continual drip so that you are constantly wet? ( )**
60. **Do you usually have difficulty starting your urine stream? ( )**

Summary:

Briefly state your urinary problem:

_____

_____

_____

_____

_____

_____

_____

_____