HOUSTON FEMALE
UROLOGY, PA
Dr. Christina Pramudji
18400 Katy Freeway, Suite 530
Houston, Texas 77094
(281)717-4003
(281)206-7597 Fax

Please see the attached new patient forms. You will only need to fill out the New Patient Form Packet. The HIPPA form, The Financial policy form, and the prescription history consent form are signed electronically when you arrive here in the office. Please also include any allergies and your pharmacy information on the medication form. You may e-mail the completed packet to us at info@houstonfemaleurology.com or they may be faxed to 281-206-7597.

PLEASE ALSO ATTACH COPY OF INSURANCE CARD (front only is ok).

Should you need to mail the packet, our address is:

18400 Katy Freeway
Suite 530
Houston, TX 77094

If you should have any questions, please give us a call or email us at info@houstonfemaleurology.com.

Once we receive your completed packet, we will contact you to set up an appointment.

Please note: Please arrive 15- 20 minutes early for your first appointment.

Thank you!

Patient Information

Name _____

Address _____ Date of Birth_____

City _____ State _____ Zip_____ Home Phone_____

Work Phone _____ Email _____

Cell Phone _____

*If patient is under 18 years of age, please provide:

Parent/Guardian Name _____

Healthcare Provider Information

Name of the physician or facility that referred you to us: _____

Name of your Primary Care Physician: _____

Contact Information for Primary Care Physician: _____

_____

(Please note: It is very important to provide phone number and/or address)

In compliance with federal guidelines, we are required to record a patient's ethnicity, race, and preferred language. Please fill in the following:

Ethnicity: Are you of Hispanic, Latino, or Spanish Origin? _____Yes _____No

Race: Please check all that apply.

_____American Indian or Alaskan Native
_____Asian
_____Black or African American
_____Native Hawaiian or Other Pacific Islander
_____White
_____Other

** The federal government considers Hispanic/Latino to be an ethnicity, not a race. That is why Hispanic/Latino is not listed as a race identification category.*

Preferred Language for HealthCare Communication: _____

Patient Name: _____

Emergency Contact

Name _____Home/Cell Phone _____

Relationship to Patient _____ Work Phone _____

Spouse or Other Contact Name _____

Phone _____

Insurance Information

Please provide current Insurance information and Identification when you check in for your appointment. Failure to provide accurate and current insurance information may result in patient responsibility for the entire bill.

Primary Insurance Company _____ (PPO? POS? OPEN CHOICE?)

Insurance ID # _____ Group # _____

Subscriber Name _____
* "Subscriber" is the person paying for the insurance coverage

Subscriber Social Security Number: __ __ __ - __ __ - __ __ __ __ Subscriber Date of Birth: _ _ /_ _ /_ _ _ _ Patient

Relationship to Subscriber: _____Self _____Spouse _____Child

Secondary Insurance Company _____

Insurance ID # _____ Group # _____

Subscriber Name _____
* Subscriber" is the person paying for the insurance coverage

Subscriber Social Security Number: __ __ __ - __ __ - __ __ __ __ Subscriber Date of Birth: _ _ /_ _ /_ _ _ _ Patient

Relationship to Subscriber: _____Self _____Spouse _____Child

I, the undersigned certify that I(or my dependent) have insurance coverage with the above listings and assign directly to Houston Female Urology all insurance benefits for service rendered. I hereby authorize Houston Female Urology to release all information necessary to secure the payment of benefits. I also authorize Houston Female Urology to release any information that is necessary if I submit a request for disability forms to be completed by my physician.

_____ _____
PATIENT SIGNATURE DATE

Patient Name: _____

***Briefly explain the reason for this visit*:_____**

_____

Pharmacy Name and phone Number: _____

Medication List

Please list all **current** medications (both prescribed and over the counter). **Use another page if more space is needed.

Medication	Dosage	Reason

Review of Systems

When completing this, please only mark symptoms you are currently (within the past 3 months) experiencing.

General ☐ No symptoms at this time ☐ Fatigue ☐ Fever ☐ Night sweats	**Cardiovascular** ☐ No symptoms at this time ☐ Chest pain ☐ Easy bruising/bleeding ☐ New rapid heartbeat	**Neurology** ☐ No symptoms at this time ☐ Memory loss ☐ Tremors
HEENT ☐ No symptoms at this time ☐ Headache ☐ Vision changes ☐ Hearing changes ☐ Nasal congestion ☐ Sore throat	**Gastrointestinal** ☐ No symptoms at this time ☐ Abdominal pain ☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Vomiting	**Genitourinary** ☐ No symptoms at this time ☐ Blood in the urine ☐ Cloudy urine ☐ Foul smelling urine ☐ Painful urination ☐ Urine leakage
Respiratory ☐ No symptoms at this time ☐ Asthma ☐ Bronchitis ☐ Cough ☐ Shortness of breath	**Psychiatric** ☐ No symptoms at this time ☐ Anxiety ☐ Bipolar Disorder ☐ Depression	**Gynecology** ☐ No symptoms at this time ☐ Vaginal discharge ☐ Yeast infection
Musculoskeletal ☐ No symptoms at this time ☐ Back pain ☐ Side pain		

Patient Name: _____

Please list all allergies and your reaction(s):

_____ _____

_____ _____

Past Medical History

Cardiovascular ☐ Atrial fibrillation ☐ Deep vein thrombosis ☐ Heart attack ☐ High cholesterol ☐ Hypertension ☐ Stroke ☐ Other: _____	**Respiratory** ☐ Asthma ☐ Bronchitis ☐ COPD ☐ Emphysema ☐ Pneumonia ☐ Pulmonary embolism ☐ Other: _____	**Gastrointestinal** ☐ Constipation, chronic ☐ Hepatitis ☐ Irritable Bowel Syndrome ☐ Stomach ulcers ☐ Ulcerative Colitis ☐ Other: _____
Genitourinary ☐ Cystocele ☐ Interstitial Cystitis ☐ Kidney stones ☐ Recurrent UTI ☐ Rectocele ☐ Other: _____	**Cancer** ☐ Bladder ☐ Breast ☐ Cervical ☐ Kidney ☐ Uterine ☐ Other: _____	**Neurology** ☐ Dementia ☐ Multiple sclerosis ☐ Parkinson's disease ☐ Other: _____
HEENT ☐ Glaucoma, narrow angle ☐ Sinusitis ☐ Sleep apnea ☐ Other: _____	**Gynecology** ☐ Bacterial vaginosis ☐ Uterine prolapse ☐ Yeast infections ☐ Other: _____	**Psychiatric** ☐ Anxiety ☐ Bipolar Disorder ☐ Depression ☐ Other: _____
Musculoskeletal ☐ Fibromyalgia ☐ Osteoporosis ☐ Other: _____	**Endocrine** ☐ Diabetes Mellitus ☐ Thyroid problems ☐ Other: _____	

Past Surgical History

Bladder Surgery ☐ Abdominal sacrocolpopexy (Year: _____) ☐ Cystocele repair (bladder lift) (Year: _____) ☐ Sling (Year: _____)	**Obstetrics** ☐ Number of pregnancies: _____ ☐ Number of vaginal deliveries: _____ ☐ Number of C sections: _____
Hysterectomy ☐ Abdominal (Year: _____) ☐ Vaginal (Year: _____) ☐ Laparoscopic (Year: _____)	**Pregnancy History** ☐ Number of Full Term**:** _____ ☐ Number of Pre Term: _____ ☐ Number of Miscarriages: _____ ☐ Number of Living: _____
Abdominal Surgery ☐ Appendix removed (Year: _____) ☐ Gallbladder removed (Year: _____) ☐ Kidney removed (Year: _____) ☐ Colon removed (Year: _____) ☐ Other	**Ovaries removed** ☐ Yes ☐ No **Bilateral Tubal Ligation** ☐ Yes ☐ No

Patient Name: _____

Family History

Please list significant family history: *(for example, "mother – Heart Disease", "Grandfather – stroke")*

_____

_____

_____

_____

_____

_____

Social History

Marital Status: _____ Occupation:_____

Tobacco Use: ☐ Never smoked ☐ Previous smoker o Year quit _____ o Number of years smoked _____ o Packs per day while smoking _____ ☐ Current smoker o Number of years smoked _____ o Packs per day _____	Drug Use: ☐ Never used ☐ Previous use o Medical or Recreational (please circle one) o Name(s) of drug(s):_____ o Year quit: _____ ☐ Current use o Medical or Recreational (please circle one) o Name(s) of drug(s):_____ o Last used: _____
Alcohol Use: ☐ Never drinker ☐ Previous use o Year quit: _____ ☐ Current drinker o Drinks per week: _____	Caffeine Use: ☐ Never used ☐ Previous use o Year quit: _____ ☐ Current use o Type: _____ o Daily consumption (please circle one): ▪ Minimal ▪ Moderate ▪ Excessive
Sexual Behaviors ☐ Currently abstinent ☐ Sexually active with one partner or multiple partners o Last sexual activity: _____	