MERCY ST. LUKE'S UROGYNECOLOGY & PELVIC REHABILITATION

Karen Liberi, MS, MPT, WCS ~ Amy Schnorberger, MS, PT, CNDT ~ Kelsey Dyer, PT ~ Peg Zientek, PTA
6005 MONCLOVA ROAD, SUITE 320 ~ MAUMEE, OH 43537
PHONE: 419 893 7134 ~ FAX: 419 893 6942

Dear _____,

You have an appointment scheduled with Mercy St. Luke's Pelvic Rehabilitation office on:

_____ at _____.

Welcome to our office. We are glad you chose us for all your personal care needs. Our office is located at ***6005 MONCLOVA ROAD, SUITE 320 ~ MAUMEE, OHIO 43537.*** *We can be reached at* ***419 893 7134, Option 5*** *if you have questions*. See directions below for office location.

Please fax, e-mail or mail all completed paperwork PRIOR to your visit.

FAX: 419 873 6812 E-MAIL: pftstaff@nwourogyn.com

It is mandatory that you bring your insurance card, driver's license, and any co-pay at the time of your visit.

We look forward to meeting you, and being able to assist with all of your needs and concerns.

Directions to the Office:

From I-475: Exit expressway at SR-24 Maumee Exit. Go East on SR-24 and follow first stop light. Turn left onto Monclova Road. Follow to Entrance #5 of Mercy St. Luke's campus and turn in to parking lot.

From Downtown Toledo: Use on-ramp for I-75 South to Anthony Wayne Trail. Follow AW Trail to Maumee (Monclova Road). Turn Right on Monclova Road. Follow to Entrance #5 of Mercy St. Luke's campus and turn into parking lot.

From Reynolds Road, West Toledo: Take Reynolds Road (US-20) that passes under the Ohio Turnpike Exit 4A, into Maumee (Conant Street) all the way to SR-24. Turn right on SR-24 and follow to Monclova Road. Turn Right on Monclova Road. Follow to Entrance #5 of Mercy St. Luke's campus and turn into parking lot.

From Ohio Turnpike: Exit at Toledo Reynolds Road Exit. Follow Reynolds Road into Maumee (Conant Street) all the way to SR-24. Turn right on SR-24 and follow to Monclova Road. Turn Right on Monclova Road. Follow to Entrance #5 of Mercy St. Luke's campus and turn into parking lot.

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PATIENT INFORMATION

Name:	SS#:	NCDS#:
Address:	Email:	
City/State/Zip:	DOB: Sex:	
Home Phone:	Marital Status:	
Cell Phone:	Emergency Contact:	
Work Phone:	Emergency Phone:	
Primary Care Physician:	Emergency Relationship:	
Language:		
Race: (circle one) White American Indian Asian Black/African American Unknown Declined		
Ethnicity: (circle one) Non-Hispanic or Latino Hispanic or Latino Declined		

INSURANCE INFORMATION

Primary Ins:	Secondary Ins:
ID #:	ID #:
Group #:	Group #:
Co-Pay:	Co-Pay:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:

Consent for Treatment: I as the patient or legal guardian of, authorize the Insurance Carrier to make checks for medical expenses due me payable to the attending staff or associated practice. I also authorize the release of any information regarding treatment to the Insurance Carrier. I further understand that I am responsible for all medical expenses and agree to pay any expenses not covered by the above Insurance Carriers. I understand that after my primary carrier has paid or rejected payment, I am responsible for the remaining balance and that billing my insurance is done of contractual obligation for participating carriers and is done only as a courtesy for other non-participating carriers.

Health Information Privacy Act (HIPAA) - Check all that apply

Home ☐ OK to leave message w/ detailed information OR ☐ Leave return phone # only
Cell ☐ OK to leave message w/ detailed information OR ☐ Leave return phone # only
Text ☐ Appointment Reminder/General message to call our office
Email ☐ Appointment Reminder/General message to call our office
Home Address: ☐ Ok to mail to my home address

☐ I permit the Practice to discuss my personal health information (PHI) with, and to disclose to, the following individuals:

Name: _____ Phone: _____
Relationship to Patient: _____
Name: _____ Phone: _____
Relationship to Patient: _____

I verify that all of the above demographic, insurance, and HIPAA information is true and correct:

_____ _____
Patient Signature Date

If signed by patient's authorized representative, describe the representative's authority: _____

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Name _____ Age _____ Date of Birth _____ Today's Date _____

Who referred you to our office? _____Primary Care Provider _____

What is the reason for your visit today? _____

Menstrual History

Age at first menstrual period _____ First day of your last period _____ If applicable: How many days do your periods last? _____
How many pads/tampons do you typically use in a 24 hours? _____ pads _____ tampons

	Yes	No	N/A
Are your menstrual cycles regular (every 21-35 days)?			
Do you have bleeding or spotting between periods?			
Do you have pain with your periods?			
Do you have pain in your lower abdomen or pelvis other than painful periods?			
If you are menopausal, have you experienced any further vaginal bleeding?			

In order to have complete medical diagnoses and treatment, please answer the following:
Gender Identity: _____Male _____ Female _____Transgender: _____ MTF _____ FTM
If applicable, preference of Gender Pronoun to be used: _____

Sexual History

	Yes	No	N/A
Are you sexually active? (If yes, please circle: with a man/woman/both)			
Do you have pain with intercourse?			
Do you have bleeding during or after intercourse?			
Are you satisfied with your current sexual health?			
Are you using birth control? If yes, what method? _____			
Have you ever had a sexually transmitted infection? If yes, please explain: _____ _____			

Pregnancy History

Total number of pregnancies: _____ Vaginal Deliveries: _____ C-Sections: _____ Miscarriages: _____
Ectopic pregnancies: _____ Abortions: _____

Have you recently had any of the following symptoms (within the last month)?

	Yes	No		Yes	No		Yes	No
Vaginal discharge			Burning or pain with urination			Pressure or bulge at the opening of the vagina		
Vulvar itching or irritation			Leakage of urine					
Breast pain			Frequent urination			Incontinence of stool		
Breast lump/mass			Difficulty emptying your bladder			Blood in your stool		
Hot flashes and/or night sweats			Urinary tract infections			Significant/chronic diarrhea		
Weight gain/loss of 10 lbs			Chronic coughing			Significant/chronic constipation		

Patient Name _____

Personal Medical History (check all that apply)

☐ Breast cancer	☐ Tension headaches	☐ Thyroid disease	☐ Jaundice/Hepatitis
☐ Ovarian cancer	☐ Migraine headaches	☐ Parkinson's disease	☐ HIV/AIDS
☐ Uterine cancer	☐ Seizures/Epilepsy	☐ Osteoporosis/osteopenia	☐ Birth defects
☐ Colon cancer	☐ Multiple sclerosis	☐ Bone fracture	☐ Exposure to DES
☐ Other cancer: _____	☐ Anxiety	☐ Vitamin D deficiency	☐ Digestive problems
☐ Abnormal pap test	☐ Depression	☐ Arthritis	☐ Breast problems
☐ Diabetes	☐ Heart attack	☐ Joint replacement	☐ Colon problems
☐ High blood pressure	☐ Stroke	☐ Lung disease _____	☐ Bladder/kidney disease
☐ High cholesterol	☐ Blood clots: _____	☐ Skin problems _____	☐ Urinary infections
☐ Heart disease	☐ Heart valve problem	☐ Anemia	☐ Glaucoma

Please provide details for any conditions selected above or list other diagnoses not above: _____

_____

_____

_____

Do you have to take antibiotics before dental work or other procedures? ☐ Yes ☐ No If yes,_____(Reason)

Drug/Food/Other Allergies (Please give reaction, i.e. hives)

☐ **N/A** (please check box if this does not apply)

_____

_____

Surgical History

Date	Procedure	Reason for Surgery
☐ **N/A** (please check box if this does not apply)		

Medications

Please list all prescription and over-the-counter medications, vitamins, and herbal supplements:

☐ **N/A** (please check box if this does not apply)

Name of medication	Dose	How often taken	Name of medication	Dose	How often taken

Patient Name _____

Pharmacy Information

	Name	Street Address	City, State Zip	Phone
LOCAL				
MAIL ORDER				

Family History

	Father	Mother	Brothers	Sisters	Sons	Daughters
How Many?	1	1				
Deceased? Yes/no						
Diagnosis:						
Diabetes						
Cardiac						
Breast Cancer						
Cervical Cancer						
Uterine Cancer						
Colon Cancer						
Bleeding Disorders						
Osteoporosis						

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Occupation: _____ ☐ Retired

How many servings of caffeine do you consume per day? _____ Type? _____

Do you currently smoke? ☐ Yes ☐ No # Cigarettes/Day: _____ How many years? _____

If no, did you ever smoke? ☐ Yes ☐ No How long ago did you quit? _____

Do you consume alcohol? ☐ Yes ☐ No How many alcoholic beverages/week? _____

Do you use illicit drugs? ☐ Yes ☐ No List: _____

In an average week, how many minutes of vigorous physical activity do you get? _____

Do you consume foods/drinks containing calcium on a daily basis? (i.e., milk, yogurt, cheese, etc.) ☐ Yes ☐ No

Please list any religious or cultural needs regarding your care: _____

Preventative History

Last Pap Smear/Pelvic Exam: _____ Facility: _____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No Treatment if applicable: _____

Last Mammogram: _____ Facility: _____

Have you ever had an abnormal mammogram? ☐ Yes ☐ No Treatment if applicable: _____

Last Bone Density Test (DEXA scan): _____ Facility: _____

Last Colonoscopy/sigmoidoscopy: _____ Facility: _____

Are you up-to-date on your immunizations? ☐ Yes ☐ No

Dates of Last: Flu: _____ Tdap: _____ Pneumonia: _____ Shingles: _____ Gardasil (HPV): _____ Covid-19: _____

Have you had any prior physical/occupational/speech or chiropractic treatments this year? ☐ Yes ☐ No How many _____