Capitol Urogynecology

Dr. Mary C. DuPont, M.D., F.A.C.S
Board Certified & Fellowship Trained
5530 Wisconsin Ave, Suite #1550
Chevy Chase, MD 20815
Phone (301) 654-5530 Fax (301) 654-5540

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I. Patient Information

*Name*_____ *DOB*_____

*Address*_____

*City*_____ *State*_____ *Zip*_____

Home Phone _____ *Cell Phone*_____

Email _____ *SSN#* _____-_____-_____

How did you hear about us? (Check one) *Pandora* ☐ *Your Health Magazine* ☐ *Washingtonian Magazine* ☐

Family/ Friend ☐_____ *Doctor Referral*☐_____ *Other* ☐_____

1) What is the **primary reason** for this appointment? _____

_____

2) **Duration** of this problem? _____

II. Insurance Information *(Please provide insurance card and valid ID)*

Primary Insurance

Responsible Party /
Subscriber Name _____ *SSN#* _____-_____-_____

Address (If Different) _____

*City*_____ *State*_____ *Zip*_____

Home Phone _____ *Cell Phone*_____ *Relationship to Patient* _____

*Occupation*_____ *Employer* _____ *Phone Number*_____

Employer Address _____

Group # _____ *Policy #* _____

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III. **Overactive Bladder Problems**? *If so, check answer to questions below.*

- Urinary **frequency** (empty bladder more than 8 times daily)? ☐ YES ☐ NO
- Urinary **leakage** while you are sleeping? ☐ YES ☐ NO
- **Sudden urges** to rush to the bathroom? ☐ YES ☐ NO
- Leakage associated with sudden urges? ☐ YES ☐ NO
- How many times do you wake up out of your sleep to urinate? _____
- How many 8 oz cups of *all* types of fluids do you drink in 24 hours (e.g., 4-6 cups, etc)? _____

IV. **Do you have urinary leakage with activities**? *If so, circle all that apply.*

Coughing Laughing Exercise Sneeze Lifting Sexual Intercourse

What is the **total # of pads** you use for urinary leakage in a 24 hour time period? _____

V. **Gynecology**

- Do you feel a vaginal bulge? *(fallen bladder, uterus, or rectum)* ☐ YES ☐ NO
- Have you used a pessary?*(not a diaphragm)* ☐ YES ☐ NO
- Are you on hormone replacement? *(pills or patch)* ☐ YES ☐ NO
- Do you use vaginal hormones? *(cream or ring)* ☐ YES ☐ NO
- How many times have you been pregnant? _____
- How many deliveries have you had? #_____*(Vaginal)* **or** #_____ *(C-section)*
- Are you postmenopausal? ☐ YES ☐ NO
- Are you sexually active? ☐ YES ☐ NO
- Do you have discomfort during sexual intercourse? ☐ YES ☐ NO
- Do you have chronic constipation? ☐ YES ☐ NO
- Do you have incontinence of stool *(fecal matter)*? ☐ YES ☐ NO

VI. **Blood in your urine?** *(hematuria)*

- Have you seen blood in your urine? ☐ YES ☐ NO
- Has your doctor diagnosed microscopic blood in your urine? ☐ YES ☐ NO
- Is there a family history of kidney or bladder cancer? ☐ YES ☐ NO
- Have you been diagnosed with kidney stones? ☐ YES ☐ NO
- Do you currently smoke? ☐ YES ☐ NO
- If so, how many years have you smoked? _____
- How many cigarettes did you smoke or are you smoking? _____

VII. **Recurrent Urinary Tract Infections**

- Are these infections documented on urine culture tests? ☐ YES ☐ NO

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- How many urine infections have you had in the past year? _____
- Are these infections linked to sexual intercourse? ☐ YES ☐ NO
- Do you have frequent UTI symptoms but most of the urine cultures have come back negative? ☐ YES ☐ NO

VIII. **Bladder or Genital symptoms**

- Do you feel constant bladder or lower abdominal discomfort? ☐ YES ☐ NO
- Do you feel genital symptoms *(pressure, burning, aching)* ☐ YES ☐ NO
- Have you been diagnosed with Interstitial Cystitis? ☐ YES ☐ NO

IX. **List all your medical problems.**

1)	4)	7)
2)	5)	8)
3)	6)	9)

X. **List all your surgeries and dates of surgeries.**

1)	4)	7)
2)	5)	8)
3)	6)	9)

XI. **List all your medications and dosages.**

1)	5)	9)
2)	6)	10)
3)	7)	11)
4)	8)	12)

XII. **List all medicines that you are allergic to:**

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1)	3)	5)
2)	4)	6)

XIII. Family History. List diseases in your blood relatives *(must complete)*

1)	3)	5)
2)	4)	6)

XIV. Would you like to hear about our aesthetic or body contouring procedures? *(hair removal, spot removal, wrinkle/scar reduction)* ☐ YES ☐ NO

XV. REVIEW OF SYSTEMS ***Required***

Eyes:	Blurred Vision	☐ YES	☐ NO
	Double Vision	☐ YES	☐ NO
Neurological:	Tremors	☐ YES	☐ NO
	Dizziness	☐ YES	☐ NO
	Numbness/tingling	☐ YES	☐ NO
Endocrine:	Excessive thirst	☐ YES	☐ NO
	Too hot/cold	☐ YES	☐ NO
	Tired/sluggish	☐ YES	☐ NO
GI:	Irritable Bowel (IBS)	☐ YES	☐ NO
	Constipation	☐ YES	☐ NO
	Indigestion/GERD	☐ YES	☐ NO
Heme:	Swollen glands	☐ YES	☐ NO
	Blood clotting problem	☐ YES	☐ NO
Allergic:	Hay fever	☐ YES	☐ NO

Skin:	Skin rash	☐ YES	☐ NO
	Boils	☐ YES	☐ NO
Muscles:	Joint pain	☐ YES	☐ NO
	Neck pain	☐ YES	☐ NO
	Back pain	☐ YES	☐ NO
ENT:	Ear infection	☐ YES	☐ NO
	Sinusitis	☐ YES	☐ NO
Lungs:	Wheezing	☐ YES	☐ NO
	Frequent cough	☐ YES	☐ NO
	Short of breath	☐ YES	☐ NO
Heart:	Chest pain	☐ YES	☐ NO
	Hypertension	☐ YES	☐ NO
	Varicose Veins	☐ YES	☐ NO
Psych:	Depression	☐ YES	☐ NO

Assignment & Release

_____ **The above information is true and accurate to the best of my knowledge.**
initial

_____ **I authorize my insurance benefit to be paid directly to Dr. Mary C. DuPont. I understand that aesthetic procedures are not typically covered by insurance.**
Initial

_____ **Dr. DuPont may be "out of network" with my insurance carrier, in which case payment is expected at the time services are rendered. I am aware that Dr. DuPont will assist me and provide a claim form to submit to my insurance carrier, as a courtesy. However, it is my sole responsibility to submit such claims.**
initial

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_____ _____

Patient Signature **Date**