Center for Urogynecology & Pelvic Reconstructive Surgery

**Fareesa Khan, M.D.**
**(PHONE) 314-270-9880**
**(FAX) 888-971-4069**

**South County**
**Saint Anthony's Medical Center**
**10004 Kennerly Road, Suite 255A**
**Saint Louis, MO 63128**

# *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
    - **Please note that our West County location accepts only CASH or CHECKS.**
- 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:_____

**Patient Information**
Name (Last, First, Middle)_____
Address (Street, city, state, zip)_____
Phone: Home_____ Cell_____ E-mail _____
Social Security Number_____ Date of birth_____
Work Status_____ Employer _____ Phone_____
**Emergency Contact**
Name _____Relationship _____ Phone _____
**Pharmacy Information**
Name_____ Phone_____
Responsible party for billing purposes (if different from above)
Name_____Relationship_____Phone_____
Address_____ Date of birth _____
**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_____
Reason for visit_____ Date of visit_____

## Medications List

| Medication Name (please include over the counter medications) | Strength/ Dosage (mg) | Number of pills per dose | Number of times taken per day |
|---|---|---|---|
| 1. _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ |
| 4. _____ | _____ | _____ | _____ |
| 5. _____ | _____ | _____ | _____ |
| 6. _____ | _____ | _____ | _____ |
| 7. _____ | _____ | _____ | _____ |
| 8. _____ | _____ | _____ | _____ |
| 9. _____ | _____ | _____ | _____ |
| 10. _____ | _____ | _____ | _____ |

## 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 _____ | |

## 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

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 menses _____ Method of birth control _____

Are you sexually Active? ___Yes ___No If yes, how long have you been with your current partner? _____