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SANJAY GANDHI, M.D.
NORTH SHORE UROGYNECOLOGY
UROGYNECOLOGY & RECONSTRUCTIVE PELVIC SURGERY
PHONE: (847) 234-1100
FAX: (847) 775-0703
WWW.PARTNERSINPELVICHEALTH.COM

Dear _____,

Your appointment is scheduled in our [Park City, Lake Forest, Woodstock, Chicago] office.

We have printed out an appointment card with the date and time of your appointments for your convenience.

Being a specialist in Urogynecology and Reconstructive Pelvic Surgery, Dr. Gandhi benefits from having specific information regarding your health history. To better help expedite your office visit, please take the time to fill out, date, and sign the enclosed information **PRIOR** to your first visit with Dr. Gandhi. Please bring **ALL** of the following to your appointment:

1. Completed and signed packet information. **Please use PEN only.**
2. A current list of any medications that you may be taking
3. A current list of any medications that you may be allergic to
4. A referral from your doctor, if necessary
5. Any records you would like Dr. Gandhi to review
6. Your current insurance information including cards & photo id
7. Please come to your first visit with a full bladder

Please feel free to call if you should have any questions or concerns.

Sincerely,

Office of Sanjay Gandhi, MD

PLEASE SEE REVERSE SIDE FOR DIRECTIONS

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Directions

Park City Office

Route 41 Heading North:
120 (Belvidere Rd) west. Stay to the right and follow signs for Fountain Square exit. Turn right (north) at stoplight turning onto Greenleaf. Building is located on the right side in the Greenleaf Square Complex.

Route 41 Heading South:
Exit Washington west. When you reach Greenleaf turn left (south). Building is located on the left side immediately past the courthouse.

Route 83 and take Route 120:
Go east on 120 Follow signs and exit Fountain Square ramp, turn left at stoplight onto Greenleaf. The Building will be on the right (east) side of street in the Greenleaf Square Complex.

Route 94 Going North:
Exit 120 (Belvidere Rd) east. Follow signs and exit the Fountain Square ramp, turn left at stop light onto Greenleaf. The building will be on the right (east) side in the Greenleaf Square complex.

Route 94 Going South:
Exit Grand Ave. east. Turn right at Route 21. From Route 21 turn left (east) onto Washington. Follow to Greenleaf light, turn right (south). Building will be on your left in the Greenleaf Square Complex.

Lake Forest Office (Campus of Lake Forest Hospital)

Our office is located on the 3rd floor of the Women's Health Center at the hospital on Westmoreland Road off of Deerpath Road. Do not go to the main entrance of the hospital.

Woodstock Office (Campus of Centegra Woodstock Hospital)

Our office is located in Medical Office Building 1 attached to the hospital on Doty Road off of Route 14.

Chicago Office (Campus of Presence Resurrection Hospital)

Our office is located on the 5th floor of Medical Office Building 3 attached to the hospital off of Talcott Avenue.

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NEW PATIENT INFORMATION

First Name _____ Middle Name _____ Last Name _____

Sex F◯ M◯ Social Security # _____ Date of Birth _____ Marital Status ____

Street Address _____ City _____ State _____ Zip Code _____

Home Tel # _____ Work Tel # _____ Cell Phone#_____

Pharmacy _____ Location _____ Pharmacy Tel #_____

Employer _____ Work Address _____

Occupation _____ Email _____

PARENT / GUARDIAN / SPOUSE INFORMATION

Name _____ Sex F◯ M◯ Social Security # _____

Mailing Address (if different) _____

Home Tel # (if different) _____ Work Tel # _____

Employer _____ Work Address _____

WHO REFERRED YOU FOR CONSULTATION?

Name: _____

◯ Family ◯Friend ◯Physician ◯Insurance Directory ◯Radio Internet◯Ad ◯Other_____

YOUR MEDICAL DOCTOR: INTERNIST / GENERAL PRACTITIONER

Name _____

Mailing Address _____

Tel # _____ Fax # _____

Did he/she refer you for a consultation? Yes◯No ◯

EMERGENCY CONTACT

❑ Same as parent / guardian / spouse information above

Name _____ Home Tel # _____ Work Tel # _____

INSURANCE INFORMATION (PLEASE FILL OUT ALL INFORMATION)

PRIMARY INSURANCE:

Name of Insured: _____ Social Security Number: _____

Address of Insured: _____ Date of Birth:___/___/___ Sex:○M ○F

_____

Telephone # of Insured: _____ Relationship to Patient ○SPOUSE ○PARENT ○GUARDIAN

Employer Name: _____

Employer Telephone: _____

Name of Insurance: _____

Group #: _____

Policy #: _____

SECONDARY INSURANCE:

Name of Insured: _____ Social Security Number: _____

Address of Insured: _____ Date of Birth:_____ Sex:○M ○F

_____

Telephone # of Insured: _____ Relationship to Patient ○SPOUSE ○PARENT ○GUARDIAN

Employer Name: _____

Employer Telephone: _____

Name of Insurance: _____

Group #: _____

Policy #: _____

Please present insurance card to the receptionist so copies may be made.

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE AND CURRENT. I ALSO UNDERSTAND THAT SHOULD THERE BE ANY CHANGES TO THIS INFORMATION, THAT IT IS MY RESPONSIBILITY TO UPDATE THIS INFORMATION. I AUTHORIZE THE PAYMENT OF MEDICAL BENEFITS FOR MYSELF (OR MY DEPENDENTS) DIRECTLY TO NORTH SHORE UROGYNECOLOGY FOR PROFESSIONAL MEDICAL SERVICES. I ALSO AUTHORIZE NORTH SHORE UROGYNECOLOGY TO SHARE AND RECEIVE INFORMATION FROM MY INSURANCE COMPANY.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

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FINANCIAL POLICY

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial policies of this office.

Payment is required for all services at the time they are rendered. For your convenience, we accept payment in the form of cash, check or credit card. As a courtesy to you, we participate in a number of insurance plans. If you are a member of one of these plans, we will file a claim with your insurance company if we have your Social Security number on file. You give us permission to appeal your insurance claims on your behalf.

PPO: Your coverage is subject to all of the terms and provisions of your insurance plan applicable at the time services are rendered. We accept payment directly from most insurance companies. We will file claims with both your primary and secondary insurance. However, before such claims are filed, you will be asked to pay any unmet deductibles, co-insurance, and co-payments. Non-covered services will not be billed to your insurance carrier, and you are responsible for the cost of these services.

HMO: It is your responsibility to ask your insurance company whether your visits to Dr. Gandhi are covered. If you need a referral, it is your responsibility to obtain this before your appointment. Any charges that are denied by your insurance company because of a missing referral are your responsibility. Non-covered services will not be billed to your insurance carrier, and you are responsible for the cost of these services.

Illinois State Law requires insurance carriers to pay claims within 30 days of receipt. Many insurance carriers have been very slow in reimbursing physicians for services rendered and are therefore not in compliance with these regulations. If we do not receive payment from your primary carrier within 60 days of filing your claim, you will be asked to pay the entire amount.

OUT OF NETWORK: If you receive any checks from you insurance carrier, you are required to submit them to our office as payment of services. You give us permission to appeal your insurance claims on your behalf.

MEDICARE: We are participating providers of Medicare and secondary insurance plans and accept Medicare assignment. Your coverage is subject to all terms and provisions of your plan applicable at the time services are rendered. You are responsible for all deductibles and co-pays, and we are required to collect them. Non-covered services will not be billed to Medicare and you are responsible for the cost of these services.

MISSED APPOINTMENTS: We make every effort to accommodate patients at the earliest opening in our schedule. A missed appointment is an inconvenience to patients, like you, waiting to see the doctor. You will be charged a $20 cancellation fee if you do not cancel a follow-up appointment 24 hours before your scheduled appointment time.

OUTSTANDING BALANCE: If any balance is not paid when due, you are responsible for all costs of collection, including attorney fees, court costs, and collection agency fees.

RETURNED CHECKS: There will be a $30 fee for all returned checks.

RECORD TRANSFER FEES: Copying records is very expensive. We are happy to provide you with copies of your records for a customary fee as allowed under Illinois law.

I understand the above financial policies and agree to comply with these policies. I give permission/consent to North Shore Urogynecology to perform diagnostic tests, procedures and treatment necessary for my condition. I authorize the payment of medical benefits for myself (or my dependents) directly to North Shore Urogynecology for professional services rendered. I authorize my insurance company to release information about my claims to North Shore Urogynecology. I permit a copy of this authorization to be used in place of the original.

_____ _____

Patient/Guardian signature Date

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Consent for Release & Use of Confidential Information & Receipt of Notice of Privacy Practice Form

I, _____, hereby give my consent to North Shore Urogynecology to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in my records.

The physician's Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that it is available for review in the office. I understand that by asking, I can receive a copy of this notice for my records.

I understand that the physician has reserved a right to change the privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available upon request. I understand that this content is valid until it is revoked by me.

I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I give permission for my prescriptions to be sent by North Shore Urogynecology electronically. This may also enable prescriptions in the system not prescribed by NSU to be viewable, which can help detect for drug to drug interactions.

☐ Check this box only if you **DO NOT** give permission for your prescriptions to be submitted electronically.

Signed:_____
Dated: _____
If you are not the patient, please specify your relationship to the patient, _____.

Consent for Participation in Patient Registry

Your participation in the Patient Registry allows us to evaluate treatments and their success rates. It also enables us to contact you if any recalls have been issued for treatments you have undergone or to present new treatment options. All data analysis is done without patient identifiers (e.g. social security numbers or names) so that your privacy is maintained.

◯ I consent to have my information included in the Patient Registry.

◯ I decline having my information included in the Patient Registry.

Signed: _____ Date: _____

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Urogynecology & Reconstructive Pelvic Surgery
Phone: (847) 234-1100
Fax: (847) 775-0703

351 S. Greenleaf Suite E., Park City, IL 60085
660 N. Westmoreland Dr., Suite 306, Lake Forest, IL 60045
3703 Doty Rd., Suite 2, Woodstock, IL 60098

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Today's Date: M O – D D – 2 0 Y Y

Social Security #: ___ – ___ – ____ Birth Date: M O – D D – Y Y Y Y

Age: ___

The main reason I am seeing the doctor is: _____

_____

_____

_____

MEDICATIONS: Please list all medications you are taking currently (including contraceptives, hormones, and vitamins) and the dosage of each:

Medication Name	Dose

Medication Name	Dose

PAST MEDICAL HISTORY

As a child did you have *(check all that apply)*:

☐ Rheumatic fever ☐ Rubella ☐ Polio
☐ Scarlet Fever ☐ Kidney Infections ☐ Bladder infections
☐ Other: _____

As an adult do you have *(check all that apply)*:

☐ Heart disease (Stents, Murmurs or Bypass Surgery)
☐ High blood pressure
☐ Arrhythmia or Pacemaker
☐ Stroke
☐ Reflux/GERD
☐ Irritable bowel syndrome
☐ Stomach/duodenal ulcers
☐ Psychiatric Illness
☐ Depression
☐ Anxiety disorder
☐ Other: _____

☐ Asthma/Bronchitis
☐ Emphysema
☐ Tuberculosis
☐ Pneumonia
☐ Sleep apnea
☐ Pulmonary Fibrosis
☐ Liver disease
☐ Kidney disease
☐ Multiple sclerosis

☐ Parkinson's disease
☐ Epilepsy /Seizure Disorder
☐ Glaucoma
☐ Fibromyalgia
☐ Diabetes
☐ Thyroid disease
☐ Cancer
☐ Bladder/Kidney ☐ Breast ☐ Other: _____
What type of treatment(s): _____

☐ Herniated Disc
☐ Sciatica
☐ Anemia
☐ Blood clots
☐ Back problems
☐ Arthritis

ALLERGIES

Do you have any drug allergies/sensitivities?..... ☐ Yes ☐ No

Please list which drugs you are allergic to and what happens when you take them.

Allergy/Sensitivity	Adverse Reaction

Allergy/Sensitivity	Adverse Reaction

SURGICAL HISTORY

Have you had a hysterectomy? ☐ Yes ☐ No

If yes: Why? _____ At what age? ☐☐

Through what type of incision? ☐ Abdominal ☐ Vaginal ☐ Laparoscopic

Have you had your ovaries removed? ☐ Yes ☐ No

Have you had any surgeries for incontinence? ☐ Yes ☐ No

If yes: list: _____

Have you had any surgeries for prolapse? ☐ Yes ☐ No

Did your surgeon use a "mesh"? ☐ Yes ☐ No

Have you had any complications? ☐ Yes ☐ No

If yes: please explain: _____

Have you had any other operations? ☐ Yes ☐ No

If yes: Please list the type of operation(s) you've had and the year or your age at the time of surgery.

Operation	Age or Year

Operation	Age or Year

Have you ever had any blood transfusions? ☐ Yes ☐ No

If yes: Did you have a reaction to any blood transfusion? ☐ Yes ☐ No

FAMILY HISTORY

Has anyone in your family had any one these diseases? If so, please check the box that gives the relationship to you. (For Aunts, Uncles, etc., indicate whether they're on your mother's side [M] or your father's side [F].

No history	Disease/Medical Condition	Mother	Father	Sister	Brother	Son	Daughter	Aunt		Uncle		Grand-mother		Grand-father	
								M	F	M	F	M	F	M	F
☐	High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Other Cancer (please list type) _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Blood Disorders or Clotting Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Urinary Incontinence	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Prolapse of the uterus or vagina	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Any hereditary conditions?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

1. Did you in the past or do you currently smoke? ◯ Yes ◯ No

   If yes: ☐ Past ☐ Current How many packs a day? ☐☐ How many years? ☐☐

2. Do you use recreational drugs? ◯ Yes ◯ No

   If yes: please list: _____

3. Do you exercise regularly? ☐ Yes ☐ No

   If yes: What type of exercises do you do: _____

   How often do you exercise? _____

SOCIAL HISTORY *(Continued)*

4. Current marital status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed
5. Number of people living in your household:..... ⌊__⌋⌊__⌋
6. Your occupation: _____
7. Spouses occupation (if applicable): _____
8. Are you sexually active?..... ☐ Yes ☐ No
9. Do you eat whole grain bread and cereal, fresh fruit and vegetables daily?..... ☐ Yes ☐ No
10. Do you use artificial sweetener? ..... ☐ Yes ☐ No

If yes: Specify type: ☐ Splenda® ☐ NutraSweet® ☐ Sweet & Low® ☐ Other:_____

Specify quantity consumed daily: _____

11. Do you typically drink any of the following: (***If yes:*** Specify type and quantity consumed daily)

Beverage	Yes	No	Type /Quantity *(e.g., "16 oz. cola" or "6 oz. red wine")*	Number per Day *(e.g. 4)*	How many years?
Soda pop	◯	◯			
Diet soda	◯	◯			
Coffee	◯	◯			
Tea	◯	◯			
Alcohol	◯	◯			

12. Do you believe that diet can affect your pelvic symptoms? ..... ☐ Yes ☐ No
13. Do you see a doctor regularly for exams? ..... ☐ Yes ☐ No

If yes: Whom? _____

14. Do you believe that there is a "Higher Power" that can help a person heal? ..... ☐ Yes ☐ No

OBSTETRIC/GYNECOLOGIC HISTORY: *Pregnancy History*

	Pregnancies	Children	Miscarriages	Abortions
Number of:	⌊__⌋⌊__⌋	⌊__⌋⌊__⌋	⌊__⌋⌊__⌋	⌊__⌋⌊__⌋

How were your babies delivered? *(List the total number delivered by each method)*

Vaginal Delivery	Vaginal Delivery with Forceps	Vaginal Delivery with Vacuum	Cesarean ***Before*** Labor ("Planned" or "Elective")	Cesarean ***After*** Contractions Began	Cesarean ***After*** "Pushing"
⌊__⌋⌊__⌋	⌊__⌋⌊__⌋	⌊__⌋⌊__⌋	⌊__⌋⌊__⌋	⌊__⌋⌊__⌋	⌊__⌋⌊__⌋

Delivery #	Vaginal (V) or C-section (C)	Episiotomy	Baby's weight	How long did you "push"?
1	☐ V ☐ C	☐ Yes ☐ No	⌊__⌋⌊__⌋ lbs ⌊__⌋⌊__⌋ oz	⌊__⌋⌊__⌋ hours
2	☐ V ☐ C	☐ Yes ☐ No	⌊__⌋⌊__⌋ lbs ⌊__⌋⌊__⌋ oz	⌊__⌋⌊__⌋ hours
3	☐ V ☐ C	☐ Yes ☐ No	⌊__⌋⌊__⌋ lbs ⌊__⌋⌊__⌋ oz	⌊__⌋⌊__⌋ hours
4	☐ V ☐ C	☐ Yes ☐ No	⌊__⌋⌊__⌋ lbs ⌊__⌋⌊__⌋ oz	⌊__⌋⌊__⌋ hours
5	☐ V ☐ C	☐ Yes ☐ No	⌊__⌋⌊__⌋ lbs ⌊__⌋⌊__⌋ oz	⌊__⌋⌊__⌋ hours

OBSTETRIC/GYNECOLOGIC HISTORY: ***Menstrual History***

Are you still having periods? ..... ☐ Yes ☐ No

If yes: Date your last menstrual period began: ..... ☐☐-☐☐-20☐☐ (M M - D D - Y Y Y Y)

Are your periods regular? ..... ☐ Yes ☐ No

Do you have heavy menstrual periods? ..... ☐ Yes ☐ No

How many pads/tampons do you use in a day? ..... ☐☐

Do you bleed between periods? ..... ☐ Yes ☐ No

Do you have pain with your periods? ..... ☐ Yes ☐ No

Are you using any birth control? ..... ☐ Yes ☐ No

If yes: What method? _____

If no: Age of Menopause: ..... ☐☐

Are you taking Hormone replacement? ..... ☐ Yes ☐ No

If yes: How long have you taken hormones? ..... ☐☐ years

PREVENTATIVE HEALTH

Date of Last Mammogram: ☐☐-☐☐-20☐☐ (M M - D D - Y Y Y Y) ..... Normal results? ..... ☐ Yes ☐ No

Date of Last DEXA or
Bone Density Scan: ..... ☐☐-☐☐-20☐☐ (M M - D D - Y Y Y Y) ..... Normal results? ..... ☐ Yes ☐ No

Date of last Pap smear: .. ☐☐-☐☐-20☐☐ (M M - D D - Y Y Y Y) ..... Normal results? ..... ☐ Yes ☐ No

Have you ever had any abnormal pap smears? ..... ☐ Yes ☐ No

If yes: Was it treated? ..... ☐ Yes ☐ No

If yes: How was it treated? _____

Have you had a colonoscopy? ..... ☐ Yes ☐ No If Yes, when: ☐☐-☐☐-20☐☐ (M M - D D - Y Y Y Y)

GYNECOLOGIC HEALTH

☐ Gonorrhea ☐ Chlamydia ☐ Pelvic Inflammatory Disease (PID)

☐ HIV ☐ Syphilis ☐ Herpes

☐ Venereal warts ☐ Hepatitis B or C ☐ Other: _____

UROLOGIC HEALTH

Have you ever had kidney or bladder stones? ..... ☐ Yes ☐ No

Is your urine ever bloody? ..... ☐ Yes ☐ No

Have you ever been treated by urethral dilation (stretching of the urethra)? ..... ☐ Yes ☐ No

If yes: When? _____ How many times? ☐☐

Did it help you? ..... ☐ Yes ☐ No

UROGYNECOLOGICAL HISTORY

1. Do you leak urine when you laugh, cough or sneeze? ..... ☐ Yes ☐ No

If yes: How many times per day or week (please specify) would you typically leak? _____

How long has this been an issue? _____

(Continued on next page)

UROGYNECOLOGICAL HISTORY *(Continued)*

2. Do you leak on the way to the restroom? ☐ Yes ☐ No

If yes: How many times per day or week (please specify) would this typically happen? _____

How long has this been an issue? _____

If you answered **Yes** to question 1 or 2, please answer the following questions.

Do you wear pads? ☐ Yes ☐ No

If yes: Quantity per day: _____

Do you wear liners? ☐ Yes ☐ No

If yes: Quantity per day: _____

Have you ever done any prior therapies for this condition? ☐ Yes ☐ No

Have you ever taken any medications for this condition? ☐ Yes ☐ No

If yes: Which ones? _____

3. Do you ever feel a bulge in the vagina? ☐ Yes ☐ No

If yes: how long has this been an issue? _____

Do you ever feel a bulge from the rectum? ☐ Yes ☐ No

4. Do you or have you ever had recurrent bladder infections? (More than 3 per year.) ☐ Yes ☐ No

If yes: For how many years has this been an issue? _____

5. Do you ever experience:

Vaginal burning? ☐ Yes ☐ No

Vaginal itching? ☐ Yes ☐ No

Vaginal discharge? ☐ Yes ☐ No

6. Do you feel any vaginal dryness? ☐ Yes ☐ No

If yes: Please list any creams/medications you have used for this: _____

7. Do you ever experience constipation? ☐ Yes ☐ No

If yes: do you take anything for it? ☐ Yes ☐ No

If yes: Please specify: _____

8. Do you ever experience diarrhea? ☐ Yes ☐ No

If yes: do you take anything for it? ☐ Yes ☐ No

If yes: Please specify: _____

9. Do you either soil or experience leakage of stool? ☐ Yes ☐ No

10. After urinating, do you feel like you completely empty your bladder? ☐ Yes ☐ No

How frequently do you urinate? _____ times per day

How many hours between the times you urinate? _____ hours

How many times do you wake up to urinate after going to sleep? _____ times per night

Do you ever get a strong urge to urinate? ☐ Yes ☐ No

Do you have pain while urinating? ☐ Yes ☐ No

Do you typically push, lean or stand to urinate? ☐ Yes ☐ No

Do you usually dribble urine as you stand up or start to walk immediatley after you have finished urinitating? ☐ Yes ☐ No

11. Are you sexually active? ☐ Yes ☐ No

If yes: Do you leak during intercourse? ☐ Yes ☐ No

Do you experience pain with intercourse? ☐ Yes ☐ No

Do you ever bleed during or after intercourse? ☐ Yes ☐ No

PELVIC FLOOR DISTRESS INVENTORY (PFDI) QUESTIONNAIRE

Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder or pelvic symptoms and if you do how much they bother you. Answer each question by putting an X in the appropriate box or boxes. If you are unsure about how to answer, please give the best answer you can. While answering these questions, please consider your symptoms over the **last 3 months.**

Name: _____ Today's Date: M M - D D - 2 0 Y Y

			If yes, how much does this bother you?			
	Yes	No	Not at all	Somewhat	Moderately	Quite a bit
1. Do you usually experience pressure in the lower abdomen?	☐	☐	☐	☐	☐	☐
2. Do you usually experience heaviness or dullness in the pelvic area?	☐	☐	☐	☐	☐	☐
3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	☐	☐	☐	☐	☐	☐
4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?	☐	☐	☐	☐	☐	☐
5. Do you usually experience a feeling of incomplete bladder emptying?	☐	☐	☐	☐	☐	☐
6. Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	☐	☐	☐	☐	☐	☐
7. Do you feel you need to strain too hard to have a bowel movement?	☐	☐	☐	☐	☐	☐
8. Do you feel you have not completely emptied your bowels at the end of a bowel movement?	☐	☐	☐	☐	☐	☐
9. Do you usually lose stool beyond your control if your stool is well formed?	☐	☐	☐	☐	☐	☐
10. Do you usually lose stool beyond your control if your stool is loose or liquid?	☐	☐	☐	☐	☐	☐
11. Do you usually lose gas from the rectum beyond your control?	☐	☐	☐	☐	☐	☐
12. Do you usually have pain when you pass your stool?	☐	☐	☐	☐	☐	☐
13. Do you usually experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	☐	☐	☐	☐	☐	☐
14. Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	☐	☐	☐	☐	☐	☐
15. Do you usually experience frequent urination?	☐	☐	☐	☐	☐	☐
16. Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	☐	☐	☐	☐	☐	☐
17. Do you usually experience urine leakage associated with a feeling of urgency; that is a strong sensation of needing to go to the bathroom?	☐	☐	☐	☐	☐	☐
18. Do you usually experience small amounts of urine leakage (that is, drops)?	☐	☐	☐	☐	☐	☐
19. Do you usually experience difficulty emptying your bladder?	☐	☐	☐	☐	☐	☐
20. Do you usually experience pain or discomfort in the lower abdomen or genital region?	☐	☐	☐	☐	☐	☐

PELVIC ORGAN PROLAPSE/URINARY INCONTINENCE
SEXUAL FUNCTION QUESTIONNAIRE (PISQ-12)

Instructions: Following are a list of questions about you and your partner's sex life. All information is strictly confidential. Your confidential answers will be used only to help doctors understand what is important to patients about their sex lives. Please check the box that best answers the question for you.

a. Have you had sex in the last 6 months? ..... ◯ Yes ◯ No

If ***yes***, please answer the questions according to your current experience.

If ***no***, please answer the questions according to the last year you were sexually active.

b. If you are not currently sexually active, why not? (please check one or more of the following)

☐ Incontinence	☐ Fear of incontinence	☐ Bladder pain	☐ Partner's lack of desire
☐ Lack of desire	☐ Chronic illness	☐ Vaginal pain	☐ Stressful situation at home
☐ Partner's impotence	☐ Burning	☐ No partner	☐ Other: _____

c. At what age did you stop sexual activity? ..... ☐☐

	Always	Usually	Some-times	Seldom	Never
1. How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex, feeling frustrated due to lack of sex, etc.	☐	☐	☐	☐	☐
2. Do you climax (have an orgasm) when having sexual intercourse with your partner?	☐	☐	☐	☐	☐
3. Do you feel sexually excited (turned on) when having sexual activity with your partner?	☐	☐	☐	☐	☐
4. How satisfied are you with the variety of sexual activities in you current sex life?	☐	☐	☐	☐	☐
5. Do you feel pain during sexual intercourse?	☐	☐	☐	☐	☐
6. Are you incontinent of urine (leak urine) with sexual activity?	☐	☐	☐	☐	☐
7. Does fear of incontinence (either stool or urine) restrict your sexual activity?	☐	☐	☐	☐	☐
8. Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum or vagina falling out)?	☐	☐	☐	☐	☐
9. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?	☐	☐	☐	☐	☐
10. Does your partner have a problem with erections that affects your sexual activity?	☐	☐	☐	☐	☐
11. Does your partner have a problem with premature ejaculation that affects your sexual activity?	☐	☐	☐	☐	☐

	Much less intense	Less intense	Same intensity	More Intense	Much more intense
12. Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?	☐	☐	☐	☐	☐

HAS URINE LEAKAGE AND/OR PROLAPSE AFFECTED YOUR:	None 0	Slightly 1	Moderately 2	Greatly 3
1. Ability to do household chores?	☐	☐	☐	☐
2. Physical recreation such as walking, swimming or exercise?	☐	☐	☐	☐
3. Entertainment activities (movies, concerts, etc.)?	☐	☐	☐	☐
4. Ability to travel by car or bus more than 30 minutes?	☐	☐	☐	☐
5. Participation in social activities outside the home?	☐	☐	☐	☐
6. Emotional condition (nervousness, depression etc.)?	☐	☐	☐	☐
7. Feelings of frustration?	☐	☐	☐	☐

Thank you for completing this questionnaire.
Please remember to bring it with you to your first office visit.