

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**

## 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 3<sup>rd</sup> 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 5<sup>th</sup> floor of Medical Office Building 3 attached to the hospital off of Talcott Avenue.

## 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  
Employer Name: \_\_\_\_\_ PARENT  
Employer Telephone: \_\_\_\_\_ GUARDIAN  
Name of Insurance: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Policy #: \_\_\_\_\_

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**SECONDARY INSURANCE:**

Name of Insured: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Address of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F  
\_\_\_\_\_  
Telephone # of Insured: \_\_\_\_\_ Relationship to Patient SPOUSE  
Employer Name: \_\_\_\_\_ PARENT  
Employer Telephone: \_\_\_\_\_ GUARDIAN  
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

## 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.

**PPQ:** 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

### **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: \_\_\_\_\_

MEDICAL HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_

Today's Date: [ ]-[ ]-[ 2 0 ]

Social Security #: [ ]-[ ]-[ ]

Birth Date: [ ]-[ ]-[ ]

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:

Table with 2 columns: Medication Name, Dose

Table with 2 columns: 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, High blood pressure, Arrhythmia, Stroke, Reflux/GERD, Irritable bowel syndrome, Stomach/duodenal ulcers, Psychiatric Illness, Depression, Anxiety disorder, Other: Parkinson's disease, Epilepsy, Glaucoma, Fibromyalgia, Diabetes, Thyroid disease, Cancer, Bladder/Kidney, Breast, Other: 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.

Table with 2 columns: Allergy/Sensitivity, Adverse Reaction

Table with 2 columns: 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
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Other Cancer (please list type) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Blood Disorders or Clotting Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Prolapse of the uterus or vagina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Any hereditary conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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			Type /Quantity <i>(e.g., "16 oz. cola" or "6 oz. red wine")</i>	Number per Day <i>(e.g. 4)</i>	How many years?
	Yes	No			
Soda pop	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Diet soda	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Tea	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

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 <b>Before</b> Labor ("Planned" or "Elective")	Cesarean <b>After</b> Contractions Began	Cesarean <b>After</b> "Pushing"
<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

Delivery #	Vaginal (V) or C-section (C)	Episiotomy	Baby's weight	How long did you "push"?
1	<input type="checkbox"/> V <input type="checkbox"/> C	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> lbs <input type="text"/> oz	<input type="text"/> hours
2	<input type="checkbox"/> V <input type="checkbox"/> C	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> lbs <input type="text"/> oz	<input type="text"/> hours
3	<input type="checkbox"/> V <input type="checkbox"/> C	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> lbs <input type="text"/> oz	<input type="text"/> hours
4	<input type="checkbox"/> V <input type="checkbox"/> C	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> lbs <input type="text"/> oz	<input type="text"/> hours
5	<input type="checkbox"/> V <input type="checkbox"/> C	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> lbs <input type="text"/> oz	<input type="text"/> hours

**OBSTETRIC/GYNECOLOGIC HISTORY: Menstrual History**

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

**If yes:** Date your last menstrual period began: .....    -   -

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:    -    -       ..... Normal results? .....  Yes  No

Date of Last DEXA or Bone Density Scan: .....    -    -       ..... Normal results? .....  Yes  No

Date of last Pap smear: ..    -    -       ..... 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:    -    -

**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 immediately after you have finished urinating? .....  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	O	D	D	2	0	Y	Y	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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you usually experience heaviness or dullness in the pelvic area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you usually experience a feeling of incomplete bladder emptying?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you feel you need to strain too hard to have a bowel movement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you feel you have not completely emptied your bowels at the end of a bowel movement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you usually lose stool beyond your control if your stool is well formed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you usually lose stool beyond your control if your stool is loose or liquid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you usually lose gas from the rectum beyond your control?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you usually have pain when you pass your stool?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you usually experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you usually experience frequent urination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you usually experience small amounts of urine leakage (that is, drops)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you usually experience difficulty emptying your bladder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you usually experience pain or discomfort in the lower abdomen or genital region?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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)

- |  |   |                                       |  |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Incontinence        | <input type="checkbox"/> Fear of incontinence | <input type="checkbox"/> Bladder pain | <input type="checkbox"/> Partner's lack of desire    |
| <input type="checkbox"/> Lack of desire      | <input type="checkbox"/> Chronic illness      | <input type="checkbox"/> Vaginal pain | <input type="checkbox"/> Stressful situation at home |
| <input type="checkbox"/> Partner's impotence | <input type="checkbox"/> Burning              | <input type="checkbox"/> No partner   | <input type="checkbox"/> 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you climax (have an orgasm) when having sexual intercourse with your partner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel sexually excited (turned on) when having sexual activity with your partner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How satisfied are you with the variety of sexual activities in you current sex life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you feel pain during sexual intercourse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you incontinent of urine (leak urine) with sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does fear of incontinence (either stool or urine) restrict your sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum or vagina falling out)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Does your partner have a problem with erections that affects your sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Does your partner have a problem with premature ejaculation that affects your sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

**Thank you for completing this questionnaire.**

**Please remember to bring it with you to your first office visit.**