Urogynecology Intake Form

Community Memorial HEALTHCARE

Name _____ DOB _____ Age _____ Date _____

Referring Physician _____ Primary Care Physician _____

GYNECOLOGIC HISTORY

Last normal menstrual period _____ age at first menstrual period _____
Length of periods _____ number of days between periods _____
Do you have clots? YES ___ NO ___
Do you have painful periods? YES ___ NO ___ Do you bleed between cycles? YES ___ NO ___

Do you have painful intercourse? YES ___ NO ___

Last Pap test _____ Any abnormal results? YES ___ NO ___
If so when? _____

Last mammogram _____ Any abnormal results? YES ___ NO ___
If so when? _____

Last colonoscopy _____ Last bone density _____

Method of contraception ___ sterilization (partner/self) ___ Depo Provera ___ IUD___ pills
___ diaphragm ___ natural family planning ___ foam/gel ___ other _____

Do you leak urine? YES ___ NO _____ all the time _____ with lifting/coughing
_____ occasionally

Do you wear incontinence pads? YES ___ NO ___ If so, how many per day? _____
Do you leak stool? YES ___ NO ___

OB HISTORY

Pregnancies _____ Births _____ Miscarriages _____ Cesareans _____ Abortions _____ None _____

MEDICAL HISTORY

___ Anemia	___ Arthritis	___ Asthma	___ Bleeding Disorder
___ Blood Transfusion	___ Breast Cancer	___ Condyloma/Warts	___ Deep Vein Thrombosis
___ Depression/Anxiety	___ Diabetes	___ Endometriosis	___ Fibrocystic Breasts
___ Fibroids	___ Fibromyalgia	___ Frequent Bladder Infection	___ Genital Herpes
___ Gonorrhea/Chlamydia	___ Heart Attack	___ Hepatitis	___ High Blood Pressure
___ High Cholesterol	___ HIV/AIDs	___ Mitral Valve Prolapse	___ Ovarian Cysts
___ Stroke	___ Thyroid Disease	___ Ulcer/GERD	___ Ulcerative Colitis

___ Other _____

SURGICAL HISTORY

Type of Surgery	Reason for Surgery	Date of Surgery

Name _____ DOB _____ Age _____ Date _____

ALLERGIES _____

MEDICATIONS (name, dosage & frequency; including supplements & herbs)

SOCIAL HISTORY

Occupation _____ How many hours do you work/week? _____

Have you ever been sexually active? YES ___ NO ___ Are you currently sexually active? YES ___ NO ___

Have you ever been raped or abused? YES ___ NO ___

Are you currently safe in your relationship? YES ___ NO ___

Do you smoke? YES ___ NO ___ FORMER ___ If yes, how many packs per day? _____ How many years? _____

Are you interested in smoking cessation? YES ___ NO ___ Maybe next year? YES ___ NO ___

How much alcohol do you drink?_____

How much coffee/tea do you drink?_____

Any recreational drugs? YES ___ NO ___ If yes, what kind?_____

How much do you exercise?_____

FAMILY HISTORY (indicate age and health issues for each)

Mother _____ Father _____

Sisters _____ Brothers _____

REVIEW OF SYSTEMS (mark any persistent symptoms you currently have)

ENDOCRINE

___ Thyroid Disease (Goiter, Nodules, Hashimoto, Graves' Disease, Hypothyroidism, Thyroid Cancer, Thyroid Surgery)

___ Parathyroid (Hyperparathyroidism, Hypoparathyroidism, Parathyroid Cancer, Parathyroid Surgery)

___ Pituitary Disease ___ Adrenal Disorder

___ Diabetes (year diagnosed?) _____ ___ Complications _____

NEPHROLOGICAL

___ Angina
___ Circulatory Problems
___ Nephritis
___ Phlebitis
___ Renal Disease
___ Rheumatic Fever

MUSCULOSKELETAL

___ Arthritis
___ Fractures
___ Gout
___ Joint Pain

HEMATOLOGICAL

___ Anemia
___ Bleeding Tendency
___ Hepatitis/Jaundice
___ HIV/AIDS
___ Swollen Glands

GASTROINTESTINAL

___ Blood in Stool
___ Colitis
___ Colon Cancer
___ Hiatal Hernia
___ Nausea/Vomiting
___ Ulcers

SKIN

___ Rashes/Hives
___ Shingles

RESPIRATORY

___ Bronchitis
___ Emphysema
___ Shortness of Breath

NEUROLOGICAL

___ Parkinson's Disease
___ Seizures
___ Stroke

CONSTITUTIONAL

___ Appetite Change
___ Cancer
___ Chills
___ Depression
___ Weight Loss

Name _____ DOB _____ Age _____ Date _____

GYNECOLOGIC

___ Breast Cancer
___ Heavy Menses
___ Hormone Replacement
___ Irregular Periods
___ Menopause
___ Ovarian Cyst/Cancer
___ PCOS
___ Uterine or Cervical Cancer

UROLOGICAL

___ Blood in Urine
___ Burning with Urination
___ Cancer
___ Pain/Urgency/Frequency
___ Stones
___ Trouble Emptying Bladder

CARDIOVASCULAR

___ Arrhythmia
___ Heart Attack Disease (angioplasty, stents, Femoral-popliteal bypass, amputations)
___ Heart Murmur
___ High Blood Pressure
___ Peripheral Vascular
___ Stroke
___ Valve Disease

Other_____

_____

_____

_____

Pelvic Floor Distress Inventory

INSTRUCTIONS

This questionnaire is necessary for your doctor to know how best to address each of your problems. You will be evaluated by a specialist in Urogynecology who focuses on pelvic floor disorders that involve bowel, bladder, and pelvic conditions.

Please answer ALL of the questions in the following survey (front/back). These are symptoms that have been recently bothering you within the last year that bring you to see the Urogynecologist. This should take you five minutes to complete.

There are two parts to each question.

1. First check the box YES or NO if you have the symptom.
2. Then, if you answer YES, please select one of your boxes indicating how much bother the symptom is causing you.

There is no right or wrong answer. Please just pick the very best, single answer.

Please disregard the scoring sections. This is for your provider to fill out if necessary.

Thank you for taking the time to fill out this questionnaire.

Center for Female Continence PFDI-20

PT Initials ____ DOB _____ Date _____ I.D. Number _____ Research Site _____

POPDI-6

Pre ☐ 3 mo ☐ 6 mo ☐ 12 mo ☐ 24 mo ☐ 36 mo ☐ 60 mo ☐

1. Usually experience **pressure in** the lower abdomen?

☐ No ☐ Yes If yes, how much does it bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit Score ___

2. Usually experience **heaviness or dullness** in the pelvic area?

☐ No ☐ Yes If yes, how much does it bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit Score ___

3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?

☐ No ☐ Yes If yes, how much does it bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit Score ___

4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?

☐ No ☐ Yes If yes, how much does it bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit Score ___

5. Usually experience a feeling of incomplete bladder emptying?

☐ No ☐ Yes If yes, how much does it bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit Score ___

6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?

☐ No ☐ Yes If yes, how much does it bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit Score ___

POPDI-6 Total x 25 = ___

Center for Female Continence PFDI-20

PT Initials ____ DOB _____ Age _____ Date _____ I.D. Number _____ Research Site _____

CRADI-8

7. Feel you need to strain too hard to have a bowel movement?

☐ No ☐ Yes If yes, how much does it bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit Score ___

8. Feel you have not completely emptied your bowels at the end of a bowel movement?

☐ No ☐ Yes If yes, how much does it bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit Score ___

9. Usually have stool escape beyond your control if your stool is well formed?

☐ No ☐ Yes If yes, how much does it bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit Score ___

10. Usually have stool escape beyond your control if your stool is loose?

☐ No ☐ Yes If yes, how much does it bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit Score ___

11. Usually lose gas from the rectum beyond your control?

☐ No ☐ Yes If yes, how much does it bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit Score ___

12. Usually have pain when you pass your stool?

☐ No ☐ Yes If yes, how much does it bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit Score ___

13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?

☐ No ☐ Yes If yes, how much does it bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit Score ___

14. Does part of your bowel ever bulge outside the rectum during or after a bowel movement?

☐ No ☐ Yes If yes, how much does it bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit Score ___

CRADI-8 Total x 25 = ___

Center for Female Continence PFDI-20

PT Initials ____ DOB _____ Age _____ Date _____ I.D. Number _____ Research Site _____

UDI-6

15. Usually experience frequent urination?

☐ No ☐ Yes If yes, how much does it bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit Score

16. Usually experience urine leakage associated with a feeling of urgency, i.e,. a strong sensation of needing to go to the bathroom?

☐ No ☐ Yes If yes, how much does it bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit Score ___

17. Usually experience urine leakage with coughing, laughing, or sneezing?

☐ No ☐ Yes If yes, how much does it bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit Score ___

18. Usually experience small amounts of urine leakage (small drops of urine)?

☐ No ☐ Yes If yes, how much does it bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit Score ___

19. Usually experience difficulty emptying your bladder?

☐ No ☐ Yes If yes, how much does it bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit Score ___

20. Usually experience pain or discomfort in the lower abdomen or genital region?

☐ No ☐ Yes If yes, how much does it bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit Score ___

UDI-6 Total x 25 = ___

Scale scores: Obtain the mean value of all the answered items within the corresponding scale (possible value 0-4) and then multiply by 25 to obtain the scale score (range 0-100). Missing items are dealt with by using the mean from answered items only.

PFDI-20 Summary Score: Add the scores from the three scales together to obtain the summary score (range 0-100).

POPDI-6_____
CRADI-8_____
UDI-6 _____

PFDI-20 Score_____

Center for Female Continence PFIQ-7

PT Initials ____ DOB _____ Date _____ I.D. Number _____ Research Site _____

Pre ☐ 3 mo ☐ 6 mo ☐ 12 mo ☐ 24 mo ☐ 36 mo ☐ 60 mo ☐

PELVIC FLOOR IMPACT QUESTIONNAIRE — short form 7

Instructions: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feelings. For each question place an X in the response that best describes how much your activities, relationships, and feelings have been affected by your bladder, bowel, or vaginal symptoms or conditions over the last three months. Please make sure you mark an answer in all three columns for each question.

How do symptoms or conditions in the following usually affect your:	Bladder or Urine	Bowel or Rectum	Vagina or Pelvis
1. Ability to do household cores (cooking, laundry, housecleaning)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
2. Ability to do physical activities such as walking, swimming or other exercise?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
3. Entertainment activities such as going to a movie or concert?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
5. Participating in social activities outside your home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
6. Emotional health (nervousness, depression, etc.)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
7. Feeling frustrated?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
Total	x 100	x 100	x 100

Scoring the PFIQ-7

All of the items use the following response scale: 0, Not at all; 1, Somewhat; 2, Moderately; 3, Quite a Bit **PFIQ-7 Score** _____

Scales:

Urinary Impact Questionnaire (UIQ-7): Seven Items under column heading "Bladder or Urine"

Colorectal-Anal Impact questionnaire (CRAIQ-7): Seven items under column heading "Bowel or Rectum"

Pelvic Organ Prolapse Impact Questionnaire (POPIQ-7): Seven items under column heading "Pelvis or Vagina"

Scale Scores: Obtain the mean value for all of the answered items within the corresponding scale (possible value 0-3) and then multiply by (100/3) to obtain the scale score (range 0-100).

Missing items are dealt with by using the mean from answered items only.

PFIQ Summary Score: Add the scores from the three scales together to obtain the summary score (range 0-300).

ePrescribing Consent Form

ePrescribing is defined as a physician's ability to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 lists standards that have to be included in an ePrescribe program. These include:

- Formulary and benefit transactions — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions — Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification — Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Community Memorial Healthcare can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name _____

Patient DOB _____

Signature of Patient or Guardian _____

Date _____

Relationship to Patient _____

Pharmacy Name _____

Acknowledgement of Notice of Privacy Practices

Legal Advice Disclaimer

This document and the information on it do not constitute legal advice. It is also not a substitute for legal or other professional advice. Users should consult their own legal counsel for advice regarding the application of the law and this document as it applies to HIPAA regulations.

Patient Name _____

I hereby acknowledge that I have received the Notice of Privacy Practices statement of Community Memorial Healthcare.

Signature of Patient _____

Date _____

Reconocimiento del Aviso de las Practicas de Privacidad

Este documento y la información en el no constituye acesoramiento jurdico. Asi como no es un substituto para consejo legal u otro consejo professional. Los usuarios debén consultar sus propios consejeros legales para consejo con respecto al uso de la ley y de este documento como aplica a las regulaciones de HIPAA.

Nombre del Paciente _____

Yo reconozco por este medio que he recibido el aviso de la Declaracion de las Practicas de Privacidad de Community Memorial Healthcare.

Firma _____

Fecha _____

To Be Completed by Staff:

Complete if signature requested but not obtained:

Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

☐ Patient/personal representative refused to sign form.

☐ Other _____

Patient Identification

Authorization to Release Medical Information to Individuals/Family Members

In accordance with federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for physicians or staff of Community Memorial Healthcare to release your medical information, we must obtain your authorization prior to doing so. However, in the event of a critical episode, or if you are unable to give your authorization due to the severity of your condition, the law stipulates that these rules may be waived. Please indicate your preferences below.

Patient Name _____

Mailing Address _____

_____

Contact Phone _____

___ I authorize Community Memorial Healthcare to send letters containing any or all of my medical information, including test results and recommendations, to the address provided above.

___ I authorize Community Memorial Healthcare to leave messages on the voice mail at the phone number provided above.

___ I authorize Community Memorial Healthcare to verbally release any or all information concerning my medical care to the following individual(s).

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I understand that it is my responsibility to inform Community Memorial Healthcare promptly in writing of any changes I wish to make to this authorization. This authorization to remain effective until _____ (not to exceed 24 months).

Patient Name _____

Date _____

Witness _____