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Intake Questionnaire

Date:	

This letter is to confirm your appointment in the Women's Pelvic Restorative Center. Please check-in 30 minutes early.

If you take an antibiotic before you go to the dentist or if you have an artificial heart valve, a catheter or a pacemaker please contact your <u>regular</u> doctor for his/her advice on the necessity of taking an antibiotic before we see you.

Please take a few minutes to review the enclosed papers. PLEASE BRING TO YOUR FIRST VISIT WITH YOU THE COMPLETED PAPERS - YOU MAY KEEP THE FIRST PAGE FOR YOURSELF. After your initial visit, there may be additional testing requested by your physician. Those appointments will be scheduled at the end of your appointment. Please note that we may have to reschedule your appointment if your paperwork is not completed in time. Enclosed you will find:

- 1. Medical history 2 pages front and back
- 2. 24 hour voiding diary directions on one side, blank to fill out on the other side
- 3. Voiding questionnaire One page front and back

In addition, please bring the following:

- 1. A copy of your most recent mammogram report (not the actual x-ray)
- 2. If you have had previous pelvic surgery, please have a copy of the OPERATIVE REPORT sent to us from your surgeon or hospital it was performed at. There is more than one surgical procedure that can be done to correct urinary incontinence or a bulge. Not knowing the exact name of the surgery that you had can potentially limit our ability to assist you.
- 3. Please bring your insurance card. All co-payments are due at the time of each visit.

For your information, we do not "double book" patients or appointments. Therefore, as a courtesy to the staff here and to other patients, we ask that you give us 24 hours notice if you must cancel or reschedule your appointment. Appointments times are for a specific time frame. Please respect the time of other patients. If you have reached the conclusion of your appointment time and need additional time to discuss your health condition, please arrange for a follow-up appointment.

Thank you for your attention to these matters. Please feel free to call if you have any questions. We look forward to meeting you.

Sincerely,

The Staff at the Women's Pelvic Restorative Center

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& Our Principal Office Visits &

Initial Consultation (30 minutes): This consultation visit will be our opportunity to get to meet you, perform an intake examination, and what additional testing (if needed) will be necessary to complete our evaluation.

Eystoscopy (20 minutes): *If necessary*, this test is performed in our office. This test uses a soft flexible tube that is attached to a camera and gives us a chance to look inside the urethra and bladder to make sure the bladder appears healthy.

Urodynamics (60 minutes): If necessary, this examination is a series of tests that allow us to look at how your lower urinary tract works. Your lower urinary tract includes the **bladder**, which stores the urine and the **urethra**, which is the tube that carries urine from your bladder to the outside.

Post-Evaluation Consultation (20 minutes): Review the results of your history, examination, and testing results. We will also discuss what options are available to address each issue.

& Please keep your appointment &

We are aware that unforeseen events sometimes require you to miss your scheduled appointment.

Please be aware that this time has been reserved exclusively for you.

If you must cancel an appointment,
please allow us at least 48 hours notice
and there will be no charges for the missed appointment.

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URINARY INCONTINENCE IN WOMEN

Urinary incontinence is a common condition. An estimated 15-30% of women experience incontinence. Although it should never be considered normal, it is significantly more common in elderly women and even more common in nursing home patients. (Men also experience urinary incontinence, but much less frequently than women and it usually occurs following radical surgery or with other neurologic disorders).

TYPES OF URINARY INCONTINENCE

The two most common types of incontinence are <u>stress urinary incontinence</u> and <u>urge incontinence</u>. Both of these types of incontinence can be effectively treated using a combination of behavior modification techniques and pelvic floor muscle exercises. Other therapy options include surgical correction for stress urinary incontinence and pharmacologic therapy for Detrusor Instability ("overactive bladder").

Stress urinary incontinence in the majority of cases is due to a loss of support to the urethra, which is the structure that carries the urine from the bladder to the outside of the body. When there is a loss of support to the urethra, urine loss can occur during activities that increase abdominal pressure (i.e. cough, sneeze, aerobic exercise, lifting, etc.). Causes of this loss of urethral support include: childbirth, which may change the structure supports of the urethra and may be the cause of pelvic floor nerve damage; chronic cough; constipation; and other conditions which tend to create chronically increased pressures within the abdomen.

Urge incontinence is the loss of urine associated with an involuntary and uncontrollable urge to urinate. Urge incontinence occurs when the bladder muscle becomes overactive and no longer responds to normal reflex, and/or central (brain) commands telling the bladder to relax. This bladder hyperactivity is called Detrusor Instability if there is no evidence of any underlying neurologic disorder. The cause of this condition is unknown. Many neurological conditions such as a stroke, Parkinson's disease, and Multiple Sclerosis can lead to similar complaints of urge incontinence.

TREATMENT OPTIONS

Numerous treatment options are available for our patient's complaint(s). Appropriate options are identified through patient assessment. Options available to patients for their complaint(s) based on their findings may include (but are not limited to) the following services offered through our clinic:

- Pessaries for urinary incontinence
- Pessaries for pelvic support problems
- Kegel exercise instruction
- Biofeedback
- Lifestyle modification for urinary incontinence
- Bladder retraining drills / voiding schedules
- Diadder retraining drins / voiding schedules
- Medication management for incontinence
- Therapy for inflammatory states of the bladder
- Surgery for pelvic support problems
- Surgery for stress incontinence

• Coordination with other support services for multiple medical complaints (including colorectal surgery, certified nutritionist assessment, and physical therapy)



who referred you to our of	ince?	
☐ Myself		
☐ A friend of mine		
Doctor / Health Car	e Provider:	
Please list th	e name(s) of you	ur physician(s) and their office address(es).
Unless you tell u	s otherwise, we w	ill keep your physician(s) informed of our work-up
treatment plan	s, and any surgeri	es that are performed for continuity of your care
Physician Name	Specialty	Office Address / Phone / Fax Number
Dr. John Doe	OB/Gyn	123 Smith Street, Houston, 77030 713-512-7000



Please list your pharmacies that you use in case we need to call in a prescription

	Name	Address	Phone number
Local			
Mail Order			
	MEI	DICAL HISTORY QUESTIONN	AIRE
DIRECTIONS	: Please read and con	plete. Thank you.	
			eted:
Please write dov	vn why you are coming	g for this evaluation and what resul	
How long have		esent (be as specific as possible):	
Please fill in the	following information	in the blanks provided.	
<u>Obstetric</u>			
Number of caesa	Pregnancies: nrean sections: ntrol method:	Miscarriages: Al	
Gynecology			
Age when period Number of days	ds started Da from start of one perio	te of last period How le	Are your periods regular? Yes / No ong does your period last?
If Y (yes		es / No Reason for menopause: Natural _ e menopause? No Yes	

Do you have any of the f ☐ Bleeding between per		? For how long?			
☐ Bleeding after interco	urse	-	For how lo	ong?	
☐ Heavy menstrual perio	ods	For how long?			
Date of last Pap smear?	ne?	Results?			
DES exposure? (DES is a drug your motl been exposed to DES wh	ier would	-	it her from having a miscarriag	ge. You	would have
☐ Cautery Da ☐ Cryosurgery Da	te	Reason Reason	yes, please indicate below)		
Gynecology (continued)					
Please circle if you had an Infection in your female of Venereal disease? Herpes?	organs?	Y/N Dat Y/N Dat	ee		
Please answer. Are you sexually active? Is your sex life satisfactor	y to you?	Y/N Y/N			
Date of last mammogram Where was your mammog	? gram don	e?Res	ult		
Past Medical History As an adult have you had					
☐ Heart Disease ☐ Liver Disease ☐ Asthma / COPD ☐ Kidney Disease ☐ Mitral Valve Prolapse ☐ Other	_ _ _	Tuberculosis Jaundice Kidney Infection	☐ High Blood Pressure☐ Thyroid disease☐ Diabetes	<u> </u>	Neurological disease Stroke
Other					

Past	Surgical History			
Have	e you had any operation	s Y/N (If yes, pl	ease list below)	
Surg	ery Month/Year	(or your age at th	ne time of surgery)	Complications (if any)
				M

Have	e you ever had a blood	transfusion? Y	es / No	
If yes	s, did you have a reacti	on? Yes / No		
N.A 3.				
	<u>icines</u> ou do any of the follow	ing?		
Smol	ou do any of the follow		ny packs per day?	Harriana?
	Alcohol? Y/N	11 yes, now ma	ny packs per day?	now long?
	street drugs? Y/N			
Hove	drug ollergieg? V / N	If you planta list	Company of the Compan	
114 40	diug aneigies: 1714	ii yes, piease iist		
Pleas	e list all medications (AND DOSES) vo	u are currently taking, including	vitamins and contracentives
				<u> </u>

		·		
<u>Fami</u>	<u>ly History</u>			
n.				
Pleas	e check if anyone in yo	<u>ur family has/had</u>	these diseases and list relations	ship.
	High blood pressure	Relationshin		
<u> </u>	Stroke	Relationship		
	Heart disease	Relationship		
	Diabetes	Relation	shin	
	Diaocics		*	
	Breast cancer			
	Other cancer	Relationship		
	Other	Relationship		
	Other	Relationship		
		A		

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Social History Please answer. Current marital status: Number of people living in your household: Your occupation: Spouse's occupation: Health Habits Please answer. How many hours do you sleep at night? Do you eat regular meals, including breakfast? Do you eat whole grain bread and cereal, fresh fruits and vegetables daily? Do you exercise regularly? If yes, what type of exercise? How often? What do you do to relax? Do you consider yourself healthy?



Review of Systems Please indicate if you have had any of the following. Circle Yes or No. If yes, please explain. Please circle "Yes" OR "No" for each response. We will not see you until every question has been circled Yes or No. NO EXCEPTIONS.

Constitutional Symptoms. Fever Chills Headache Other Eyes Blurred Vision Double Vision Pain	Y/N Y/N Y/N Y/N Y/N Y/N	Integumentary Skin Rash Y/N Boils Persistent Itch Other Musculoskeletal Joint Pain. Y/N Neck Pain Y/N Back Pain Y/N	Y/N Y/N
Other Allergic/Immunologic Hay Fever Drug Allergies Other Other Neurological	Y/N Y/N	Other Ear/Nose/Throat/Mouth Ear Infection Sore Throat Sinus Problems Y / N Genitourinary	Y/N Y/N
Tremors Dizzy spells Numbness/tingling Other Endocrine	Y/N Y/N Y/N	Urine retention Y / N Painful urination Y / N Urinary frequency Other Respiratory	Y/N
Excessive thirst Too hot/cold Tired/sluggish Other Gastrointestinal	Y/N Y/N Y/N	Wheezing Y/N Frequent cough Y/N Shortness of breath Other Hematologic/Lymphatic	Y / N
Abdominal pain Nausea/vomiting Indigestion/heartburn Other Cardiovascular	Y/N Y/N Y/N	Swollen glands Blood clotting problem Other Psychologic	
Chest pain Varicose veins High blood pressure Other	Y/N Y/N Y/N	Are you generally satisfied with your life? Do you feel severely depressed Have you considered suicide?	
Physician use only: (Comment/No	otes)	# Answer Level of S 0-1 l or 0-2 2-9 3	
MD/Date:		>10 4 or	5



VOIDING DIARY (UROLOG)

THIS CHART IS A RECORD OF YOUR VOIDING (URINATING) AND LEAKAGE (INCONTIENCE) OF URINE. PLEASE READ THE DIRECTIONS CAREFULLY AND COMPLETE THIS SHEET PRIOR TO YOUR FIRST APPOINTMENT. CHOOSE A 24 HOUR PERIOD TO KEEP THIS RECORD WHEN YOU CAN MEASURE EVERY VOID. START THE CHART WITH THE FIRST VOID WHEN YOU GET UP IN THE MORNING.

WE REALIZE THIS MAY BE AN INCONVENIENCE, BUT THE INFORMATION IT PROVIDES IS VERY IMPORTANT IN ASSESSING YOUR BLADDER PROBLEM. WE MAY HAVE TO RESCHEDULE YOUR APPOINTMENT IF THIS DIARY IS NOT AVAILABLE AT YOUR FIRST APPOINTMENT.

YOU MAY MEASURE AMOUNTS IN OUNCES OR IN CC'S-BUT PLEASE INDICATE WHICH YOU ARE USING.

NOTE: 1 CUP = 8 OUNCES = 240 CC'S

1. TIME Record time of every time you void. leak or drink.

2. AMOUNT VOIDED Measure and write down amount of urine voided.

3. ACTIVITY Write down what you were doing when you leaked or lost control of your bladder.

Examples are: getting out of a chair, bending over, vacuuming, gardening, doing dishes, taking shower, etc. If you were NOT doing anything active, write down

whether you were standing, sitting or lying down.

4. AMOUNT LEAKED Estimate the amount you leaked according to this scale:

1 = damp, few drops only.

2 = wet underwear or pad.

3= soaked pad or clothing or bladder emptied completely.

5. URGE PRESENT If you had an urge to void before or at the time of the leakage write YES.

If there was NO urge or you didn't realize you were voiding write NO

6. <u>AMOUNT AND</u> Measure and

TYPE OF FLUID

Measure and write down the amount and type of all liquids you drink.



NAME:	
VOIDING DIARY (UROLOG)	

TIME	AMOUNT VOIDED	ACTIVITY	AMOUNT LEAKED	URGE PRESENT	AMOUNT AND TYPE OF FLUID
6:45 am	500 cc	Waking up		No	TEOID
7:00 am		Turned on water	2	Yes	1 cup of coffee 8 oz orange juice
			A-0-1-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-		



NAME:		DATE:		
Do you experience, and if so, how much are you bothered by:	Not at All	Slightly	Modera	tely Greatly
Urine leakage related to the feeling of urgency (sudden desire to urinate)?	0	1	2	3
Urine leakage related to physical activity, coughing, or sneezing?	0	1	2	3
5. Small amounts of urine leakage (drops)?	0	1	2	3
6. Difficulty emptying your bladder?	0	1	2	3
7. Pain or discomfort in the lower abdominal or genital area?	0	1	2	3
Uragenital Distress Inventory-Short form (UD1-6 Scoring, Henr responses are assigned values of 0 for "not at all," 1 for "stightly," 2 for "modera is multiplied by 33 1/3 to put scores on a scale of 0 to 100. Quality of life due to urinary problems If you were to spend the rest of your life with your urinar Please draw an "X" across the scale below to best refle	y condition just	the way it is no	ow, how wou	uld you feel about that
Pleased				Terrible
	· ·			

Some people find that accidental urine loss may affect their activities, relationships, and feelings. The questions below refer to areas in your life that may have been influenced or changed by your problem. For each question, circle the response that best describes how much your activity, relationships, and feelings are being affected by urine leakage.

Has urine leakage affected your	Not at All	Slightly	Moderately	Greatly
Ability to do household chores (cooking, house cleaning, laundry)?	0	1	2	3
Physical recreation such as walking, swimming, or ot exercise?	ner 0	1	2	3
3. Entertainment activities (movies, concerts, etc.)?	0	1	2	3
Ability to travel by car or bus more than 30 minutes from home?	0	1	2	3
5. Participation in social activities outside your home?	0	1	2	3
6. Emotional health (nervousness, depression, etc.)?	0	1	2	3
7. Feeling frustrated?	0	1	2	3

Incontinence Impact Questionnaire-Short Form IIQ-7

Items 1 and 2 = physical activity, 3 and 4 = travel, 5 = social/relationships, 6 and 7 = emotional health

Scoring. Item responses are assigned values of 0 for "not at all," 1 for "slightly," 2 for "moderately," and 3 for "greatly." The average score of items responded to is calculated. The average, which ranges from 0 to 3, is multiplied by 33 1/3 to put scores on a scale of 0 to 100.



NAME:	DATI	E:		
These questions ask about symptoms you may have relat represents how frequently you experience each symptom.		eakage. Ple		
	0 Never	1 Rarely	2 Sometimes	3 Often
Does coughing gently cause you to lose urine?				
Does coughing hard cause you to lose urine?				
Does sneezing cause you to lose urine?				
Does lifting things cause you to lose urine?				
Does bending cause you to lose urine?				
Does laughing cause you to lose urine?				***************************************
Does walking briskly or jogging cause you to lose urine?				
Does straining, if you are constipated, cause you to lose urine?)*************************************
Does getting up from a sitting to a standing position cause you to lose urine?				
Some women receive very little warning and suddenly find that they are losing, or are about to lose, urine beyond their control. How often does this happen to you?				
If you can't find a toilet or find that the toilet is occupied, and you have an urge to urinate, how often do you end up losing urine or wetting yourself?				
Do you lose urine when you suddenly have the feeling that your bladder is very full?				
Does washing your hands cause you to lose urine?				
Does cold weather cause you to lose urine?				
Do drinking cold beverages cause you to lose urine?				

MESA Questionnaire

Urge incontinence: maximum total score is 18 based on 6 questions, with a maximum score of 3 for each question.

Stress incontinence: maximum score is 27, based on a question with a maximum score of 3 for each question.

Determine predominance: urge score divided by 18 x 100 vs. stress score divided by 27 x 100



INSTRUCTIONS

have been affected by your bladder, bowel or vaginal symptoms or conditions <u>over the last 3 months</u>. You may or each question. If do not have symptoms in one of these areas, then the appropriate answer would be "Not at all" in may not have symptoms in each of these three areas, but please be sure to mark an answer in all 3 columns for each question, place an X in the response that best describes how much your activities, relationships or feelings Some women find that bladder, bowel or vaginal symptoms affect their activities, relationships, and feelings. For the corresponding column for each question.

EXAMPLE

For the following question:

drive a car or you have no vaginal or pelvic symptoms then you should place an X in the corresponding boxes as If your bladder symptoms interfere with your ability to drive a car moderately, and your bowel symptoms interfere with your ability to drive a car somewhat, but your vaginal or pelvic symptoms do not interfere with your ability to indicated below:

How do symptoms or conditions related to the following substitutions or conditions related to the following substitutions. →	→→→→ Bladder or	Bowel or rectum	Vagina or Pelvis
1. ability to drive a car	□ Not at all □ Somewhat Moderately □ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	Not at all Somewhat Moderately

Please make sure to answer all 3 columns for each and every question.

Thank you for your cooperation

WOMEN'S PELVIC RESTORATIVE CENTER

	Rladdon	Rladdow or mino	-	Bowel or		Vagina or
the following usually affect your	Diagael	טו מווונכ		rectum	\$ 0.0 To 0.0 - 48 to 0.0 To	Pelvis
A L. 11. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4.		Not at all		Not at all	σ	Not at all
1. Ability to do nousehold chores	Sor	Somewhat		Somewhat		Somewhat
(cooking, house cleaning, laundry)?		Moderately		Moderately	0	Moderately
	O D	Quite a bit	0	Quite a bit	0	Quite a bit
	No	Not at all		Not at all		Not at all
2. Physical recreation such as walking swimming or other exercise?		Somewhat		Somewhat		Somewhat
		Moderately		Moderately		Moderately
		Quite a bit		Quite a bit	0	Quite a bit
	o i	Not at all		Not at all	0	Not at all
 Entertainment activities (movies, concerts, etc.)? 	Soz	Somewhat		Somewhat		Somewhat
	Š.	Moderately		Moderately		Moderately
	O O	Quite a bit		Quite a bit		Quite a bit
	₽ N	Not at all		Not at all	0	Not at all
4. Ability to travel by car or bus more than 30	Sor	Somewhat		Somewhat		Somewhat
minutes from home?	Š.	Moderately		Moderately		Moderately
		Quite a bit		Quite a bit	۵	Quite a bit
	Not I	Not at all		Not at all	٥	Not at all
 Participation in social activities outside your home? 	Sor	Somewhat		Somewhat		Somewhat
	ğ,	Moderately		Moderately		Moderately
	ō o	Quite a bit		Quite a bit		Quite a bit
	Not I	Not at all		Not at all	٥	Not at all
b. Emotional health (nervousness, depression, etc.)?	Soz	Somewhat		Somewhat		Somewhat
	Š	Moderately		Moderately		Moderately
	O O	Quite a bit		Quite a bit		Quite a bit
:	Ş Not	Not at all		Not at all	0	Not at all
/. reeling trustrated?		Somewhat		Somewhat		Somewhat
	Š.	Moderately		Moderately	0	Moderately
	3	Quite a bit		Quite a bit	0	Quite a bit



Name:	Date:
-------	-------

Instructions:

Please answer these questions by putting an **X** in the appropriate box. If you are unsure about how to answer a question, give the best answer you can. While answering these questions, please consider your symptoms over the **last 3 months**. Thank you for your help.

		Not at all	Somewhat	Moderately	Quite a bit
Do you usually experience pressure in the lower abdomen?	 □ No → Go to next question □ Yes→ how much does this bother you? → 	1	2	3	4
2. Do you usually experience heaviness or dullness in the pelvic area?	☐ No → Go to next question☐ Yes→ how much does this bother you? →	1	2	3	4
3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	☐ No → Go to next question☐ Yes→ how much does this bother you? →	1	2	3	4
4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?	☐ No → Go to next question☐ Yes→ how much does this bother you? →	1	2	3	4
5. Do you usually experience a feeling of incomplete bladder emptying?	☐ No → Go to next question☐ Yes→ how much does this bother you? →	1	2	3	4
6. Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	☐ No → Go to next question☐ Yes→ how much does this bother you? →	1	2	3	4
7. Do you feel you need to strain too hard to have a bowel movement?	☐ No → Go to next question☐ Yes→ how much does this bother you? →	1	2	3	4
8. Do you feel you have not completely emptied your bowels at the end of a bowel movement?	 □ No → Go to next question □ Yes→ how much does this bother you? → 	1	2	3	4
9. Do you usually lose stool beyond your control if your stool is well formed?	☐ No → Go to next question☐ Yes→ how much does this bother you? →	1	2	3	4
10. Do you usually lose stool beyond your control if your stool is loose or liquid?	☐ No → Go to next question☐ Yes→ how much does this bother you? →	1	2	3	4

Name:

		Not at all	Somewhat	Moderately	Quite a bit
11. Do you usually lose gas from the rectum beyond your control?	☐ No → Go to next question☐ Yes→ how much does this bother you? →	1	2	3	4
12. Do you usually have pain when you pass your stool?	☐ No → Go to next question☐ Yes→ how much does this bother you? →	1	2	3	4
13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	☐ No → Go to next question☐ Yes→ how much does this bother you? →	1	2	3	4
14. Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	 □ No → Go to next question □ Yes→ how much does this bother you? → 	1	2	3	4
15. Do you usually experience frequent urination?	☐ No → Go to next question☐ Yes→ how much does this bother you? →	1	2	3	4
16. Do you usually experience urine leakage associated with a feeling of urgency that is a strong sensation of needing to go to the bathroom?	☐ No → Go to next question☐ Yes→ how much does this bother you? →	1	2	3	4
17. Do you usually experience urine leakage related to coughing, sneezing, or laughing?	☐ No → Go to next question☐ Yes→ how much does this bother you? →	1	2	3	4
18. Do you usually experience small amounts of urine leakage (that is, drops)?	☐ No → Go to next question☐ Yes→ how much does this bother you? →	1	2	3	4
19. Do you usually experience difficulty emptying your bladder? ☐ No → Go to next question ☐ Yes→ how much does this bother you? →		1	2	3	4
20. Do you usually experience pain or discomfort in the lower abdomen or genital region?	☐ No → Go to next question☐ Yes→ how much does this bother you? →	1	2	3	4

Pelvic Floor Distress Inventory – Short Form 20



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. While answering the questions, consider your sexuality over the past six months. Thank you for your help.

1.	How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex, felling frustrated due to lack of sex, etc.	Always	Usually	Sometimes	Seldom	Never
2.	Do you climax (have an orgasm) when having <u>sexual intercourse</u> with your partner?	Always	Usually	Sometimes	Seldom	Never
3.	Do you feel sexually excited (turned on) when having sexual activity with your partner?	Always	Usually	Sometimes	Seldom	Never
4.	How satisfied are you with the variety of sexual activities in your current sex life?	Always □	Usually	Sometimes	Seldom	Never
5.	Do you feel pain during sexual intercourse?	Always .	Usually	Sometimes	Seldom	Never
6.	Are you incontinent of urine (leak urine) with sexual activity?	Always	Usually	Sometimes	Seldom	Never
7.	Does fear of incontinence (either stool or urine) restrict your sexual activity?	. Always	Usually	Sometimes	Seldom	Never
8.	Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum or vagina falling out?)?	Always	Usually	Sometimes	Seldom □	Never
9.	When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?	Always	Usually	Sometimes	Seldom	Never
	Does your partner have a problem with erections that affects your sexual activity?	Always	Usually	Sometimes	Seldom	Never
	Does your partner have a problem with premature ejaculation that affects your sexual activity?	Always	Usually	Sometimes	Seldom	Never □
12.	Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?	Much less of the time □	Less intense □	Same intensity □	More intense □	Much more intense

Name	;	Date:
		check in <u>a single box</u> next to the description that best matches your current bowel habits.
		Type 1 Separate hard lumps, like nuts
		Type 2 Sausage-like but lumpy
		Type 3 Like a sausage but with cracks in the surface
		Type 4 Like a sausage or snake, smooth and soft
		Type 5 Soft blobs with clear-cut edges
		Type 6 Fluffy pieces with ragged edges, a mushy stool
		Type 7 Watery, no solid pieces
When	(if eve	r) was your last colonoscopy and what were the results?
If you	checke	ed off a box for Type 1, Type 2, or Type 3: Have you had stool like this for 3 months or greater?
	Yes	
	No	
<u> Do yoι</u>	ı have	any of the following?
Yes	No	
		Unintended weight loss greater than 10 pounds
		Onset of constipation after the age of 50 that has not been evaluated by a colon/GI doctor
		Family history of colon cancer
		Anemia



Peter M. Lotze, M.D.

Ginger N. Cathey, M.D.

Kimberly R. Miller-Miles, M.D.

Hilaire W. Fisher, M.D.

CLINIC FINANCIAL POLICY

We charge a \$25 fee for missed clinic appointments or appointments cancelled with less than twenty-four hours notice. We charge \$50 for missed procedure (urodynamics, cystoscopy, etc) appointments or appointments cancelled with less than twenty-four hours notice. These charges are not billable to your insurance company and you will be responsible for payment of this charge. Missed appointments often mean that someone else was not able to be seen in a more timely fashion. Please be courteous, cancel or reschedule your appointment as early as possible.

SURGERY RESCHEDULING & CANCELLATION POLICY

Please carefully consider your surgical date prior to scheduling. Your surgery requires the coordination of numerous individuals, including our staff, your surgeon, the anesthesiology department and the hospital. Rescheduling procedures requires significant time and expense, particularly if the operating room goes unused because of a late cancellation. Please be courteous and promptly make our staff aware of any decision to reschedule or cancel your surgery.

- -You will be asked to pay any fees you may owe for coinsurance or deductibles prior to your surgery. If for some reason your surgery is cancelled and not rescheduled, you will receive a refund for that amount.
- -If you reschedule or cancel your surgery with less than 2 week notice, there is a mandatory fee of \$100 and must be paid prior to placing your surgery back on the schedule.
- -If you reschedule or cancel your surgery for any reason with less than 72 hours notice, there will be a mandatory fee of \$200 and must be paid prior to placing your surgery back on the schedule.

Printed Name:	Date:
Signature:	

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