WOMEN'S CENTER FOR PELVIC HEALTH

New Patient Packet

We are looking forward to your upcoming visit with us.

In order to facilitate your visit, please complete the following forms before your scheduled appointment. These forms will be collected at check-in.

To better serve your needs, we have practices in the two locations listed below. If you have any questions prior to your visit, please contact the respective office at the number listed below.

Charlotte:
2001 Vail Ave. Suite 360
Charlotte, NC 28207
Tel:704-304-1160
Fax: 704-304-1162

Concord:
200 Medical Park Dr. Suite 250
Concord, NC 28025
Tel: 704-403-6350
Fax: 704-403-6351

☐**Michael Kennelly, MD**
☐**Amber Herr, PA**

☐**Erinn Myers, MD**
☐**Kevin Stepp, MD**
☐**Laura Brack, NP**

☐**G. Bernard Taylor, MD**
☐**Megan Tarr, MD**
☐**Kristi Benjamin, PA**
☐**Deborah Terzis, NP**

Appointment date/time:

WOMEN'S CENTER FOR PELVIC HEALTH

Last Name_____First_____Middle_____DOB_____ AGE_____

S.S. #_____ Address_____ County_____ City_____

State_____ Zip _____Home #____/_____Business #____/_____Mobile #_____/_____

Race ☐ African American ☐ Caucasian Sex_____ Marital Status_____ Maiden Name_____
☐ Native American ☐ Hispanic ☐ Other

Religious Pref._____ Name of Church_____ Occupation _____

Name of Employer or School_____ Employer/School Address_____

(Circle One) Full time/ Part time/ Disabled Employer/School #_____/_____

(In case of emergency, whom should we notify?) Name_____ Address_____

Relationship to Patient_____ Home #____/_____ Business #____/_____

Person Responsible for Bill_____ Relationship to patient_____
Last Name First Name Middle or Maiden

DOB_____ S.S#_____ Home #____/_____ Address_____
(If different from patient)

Name of Employer & Address_____ Work #____/_____

Occupation_____ (Circle One) Full time/ Part time/ Disabled

INSURANCE INFORMATION

PRIMARY	**SECONDARY**
/	Additional Insurance ☐ Yes ☐ No
Name of Employer Business #	Subscriber Name Relationship to Patient
Insurance Company Name	Insurance Company Name
Insurance Co. Address City State Zip	Insurance Co. Address City State Zip
Group Name	Group Name
Policy # or SS#	Policy # or SS#

ADDITIONAL INFORMATION

Does Medicare cover patient? ☐Yes ☐ No Is patient retired? ☐ Yes ☐ No Date of Retirement

Is spouse retired? ☐ Yes ☐ No Date of Retirement_____ Black Lung Benefit Yes ☐ No ☐

Is this condition due to an accident? ☐ Yes ☐ No Date Condition Started_____

DVA authorized and agreed? ☐ Yes ☐ No Is this service paid by gov't program? ☐Yes ☐No Name of program_____

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NEW PATIENT HISTORY/QUESTIONNAIRE
(Please complete to the best of your ability)

Name:	
Date of birth:	
Age:	
Referring physician:	
Name of practice:	
Phone number:	
Primary care physician:	
Name of practice:	
Phone number:	

List other physicians/medical practice currently involved in your care (example: cardiologist, nephrologist, pulmonologist)

1.	
2.	
3.	
4.	

Please describe the main reason for your appointment:

_____

_____

_____

_____

Are your current symptoms: ☐ Worsening ☐ Static ☐ Improving

On a scale of 0-10, how much do your current symptoms bother you (0 = not at all; 10 = intolerable)?
_____ out of 10.

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BLADDER SYMPTOMS (please check ☒ all that apply)

How often do you urinate during waking hours?

☐ Every hour or more often ☐ Every 1-2 hours. ☐ Every 2-3 hours. ☐ Every 4 hours or more.

How often do you wake up at night to urinate?

☐ Never or rarely. ☐ Usually 1 time per night. ☐ 2-3 times per night. ☐ 4 or more times per night.

Do you have a strong urge to urinate and/or do you have to hurry to the bathroom to urinate?

☐ Never or rarely. ☐ Occasionally. ☐ Daily.

Irritative voiding symptoms

☐ I have difficulty getting to the bathroom in time? ☐ I need to void when I hear running water?

☐ I need to void when rising from a seated position?

Obstructive voiding symptoms:

☐ I have a slow stream and/or have difficulty starting my urine stream (hesitancy).

☐ I need to strain/push to begin urination (Crede).

☐ I have difficulty emptying my bladder.

☐ My urine stream stops and starts before my bladder is empty (intermittency).

☐ I have to reposition my body in order to empty my bladder (pelvic tilt).

☐ I have to push on my abdomen to help empty my bladder.

☐ I have to catheterize in order to empty my bladder.

Incontinence symptoms:

☐ I leak urine.

☐ During the daytime ☐ During the night ☐ Continuously ☐ Without awareness

Check all activities when you leak urine:

☐ Coughing ☐ Sneezing ☐ Laughing ☐ Lifting ☐ Exercising

☐ Sports activities ☐ Change of position ☐ Sexual intercourse ☐ Walking ☐ Other activities

How much urine do you leak?

☐ A small amount, just a few drops. ☐ A moderate amount (more than a few drops, dribbling) ☐ A large amount (total saturation, flooding)

☐ I wear pad protection. ☐ Mini pads/panty liners ☐ full pads ☐ Adult diapers

How may pads do you use in an average day? _____ pads per day.

Describe your pads when you change them:

☐ dry ☐ moist ☐ damp ☐ wet ☐ soaked/saturated

PROLAPSE SYMPTOMS (please check ☒ all that apply)

☐ Vaginal pressure or vaginal heaviness. ☐ Tissue protrudes outside the vagina.

☐ Vaginal pain ☐ Abdominal pressure.

☐ Need to push the tissue back to help with urination and/or bowel movements.

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BOWEL SYMPTOMS (please check ☒ all that apply)

- ☐ Problems with constipation
- ☐ Fecal urgency
- ☐ Incontinence of liquid stool
- ☐ Feeling of incomplete bowel emptying
- ☐ Painful bowel movements
- ☐ Incontinence of flatus (gas)
- ☐ Incontinence of solid stool
- ☐ Laxative use. How often do use laxatives each week? _____ times per week
- ☐ Need for use of digital manipulation to help empty bowels

SEXUAL FUNCTION SYMPTOMS (please check ☒ all that apply)

- ☐ I am currently sexually active.
- ☐ I am not currently sexually active.
- ☐ I have pain with intercourse.
- ☐ I have vaginal dryness/lack of lubrication with intercourse.
- ☐ I have lack of desire for intercourse.
- ☐ I have inadequate arousal for intercourse.

GENERAL SYMPTOMS (please check ☒ all that apply)

- ☐ Blood in urine
- ☐ Pain with urination
- ☐ Urinary tract infections — Approximate date of last infection: _____
- ☐ Kidney infections (pyelonephritis)?
- ☐ Kidney stones — Approximate date of last infection: _____

PAST MEDICAL HISTORY

Please check ☒ all past and/or current illnesses/medical conditions that apply:

- ☐ Alzheimer's/dementia
- ☐ Asthma
- ☐ Blood clot/DVT
- ☐ Cancer/Type: _____
  - ☐ Radiation ☐ Chemotherapy ☐ Surgery
- ☐ Depression
- ☐ Endocrine disorder/gland problem//Thyroid
- ☐ Heart murmur
- ☐ Hypercholesterolemia (elevated cholesterol)
- ☐ Glaucoma
- ☐ Liver disorder (cirrhosis, hepatitis)
- ☐ Multiple sclerosis
- ☐ Sleep apnea:
- ☐ Parkinson's
- ☐ Anemia
- ☐ Arthritis
- ☐ Cardiac arrhythmia
- ☐ Congestive heart failure
- ☐ Cerebrovascular disease/stroke
- ☐ Other heart disease
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Hypertension
- ☐ Other lung disorders
- ☐ Kidney stones
- ☐ Kidney failure
- ☐ Mitral valve prolapse
- ☐ Other (specify) _____

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PAST SURGICAL HISTORY

Procedures: **Date/year**

☐ Appendectomy

☐ Tonsillectomy

☐ CABG

☐ Cholecystectomy (removal of gallbladder)

☐ Lithotripsy/ESWL (stone machine)

☐ Hernia repair

☐ Mastectomy ☐ right ☐ left

☐ Bladder suspension

☐ Cystocele repair

☐ Rectocele repair

☐ Hysterectomy ☐ Abdominal ☐ Vaginal ☐ Laparoscopic

☐ Removal of ovary ☐ right ☐ left

☐ Other

OB/GYN HISTORY

How old were you when you began to menstruate? _____ years old.

☐ I have regular menstrual cycles. Date of last period: _____ (date)

Length of average period: _____ days Average number of days between periods: _____ days

☐ I use hormone replacement therapy.

☐ I no longer have periods. Date of last period: _____ (date)

Number of pregnancies: _____ Number of vaginal deliveries: _____

Weight of largest child: _____ Number of C-Section deliveries: _____

☐ I have regular/annual PAP smears. Date of last PAP smear: _____ (date)

☐ I have a history of abnormal PAP smear and was treated or am currently being followed.

☐ I have regular screening mammograms. Date of last mammogram: _____ (date)

☐ I have a history of abnormal mammogram and am currently being evaluated or treated.

☐ Sexual abuse. ☐ Current ☐ Past

☐ Domestic violence. ☐ Current ☐ Past

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FAMILY MEDICAL HISTORY

(Please ☒ all that apply to family members: parents, grandparents, siblings)

☐ Cancer – Type – Family member(s):

_____

☐ Diabetes: _____

☐ Heart Disease: _____

☐ Stroke: _____

☐ Other (specify): _____

Mother: ☐ Alive ☐ Deceased Mother's medical conditions:_____

Father: ☐ Alive ☐ Deceased Father's medical conditions: _____

SOCIAL HISTORY

(please check ☒ all that apply)

☐ Married (living with spouse or partner) ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Level of education:

☐ Grade school ☐ High school/equivalent ☐ Some college ☐ College degree ☐ Graduate degree

Employment – Occupation: _____

☐ Employed full time ☐ Employed part time ☐ Unemployed ☐ Disabled ☐ Retired

Alcohol use:

☐ I use alcohol. ☐ I do not use alcohol. ☐ I no longer use alcohol, but did in the past.

_____ of drinks per week. Number of years of this pattern: _____ years.

☐ I currently use recreational drugs and/or marijuana. ☐I have never used recreational drugs and/ or marijuana.

☐I have use drugs or marijuana in the past.

Tobacco use/smoking history:

☐ None/I never use tobacco products.

☐ I use tobacco products. _____ of packs per day.

How long (how many years) have you used tobacco? _____ years.

☐ Other tobacco use (snuff/dip/chew), please specify:

_____

☐ I previously used tobacco products, but do not use tobacco at this time.

☐ I quit using tobacco (date/year): _____.

☐ Recreational drug use (please specify):_____

Caffeine use:

☐ None – I drink no caffeinated beverages.

☐ I drink caffeinated beverages

# of 8 oz. cups of coffee per day: _____

# of 12 oz. glasses of tea per day: _____

# of 12 oz. glasses of soda per day: _____

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Medication name	Amount (mg/mcg)	Frequency (how often per day)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

Medication allergies

Name	Reaction
1.	
2.	
3.	
4.	
5.	
6.	

Are you allergic to Betadine? ☐ **Yes** ☐ **No**

Are you allergic to IV contrast dye? ☐ **Yes** ☐ **No**

Are you allergic to Latex? ☐ **Yes** ☐ **No**

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10 System Review of Systems
(Please ☒ all that apply)

General
- ☐ recent weight gain or loss
- ☐ fever
- ☐ chills
- ☐ sweats
- ☐ weakness

Endocrine & Metabolic
- ☐ excessive thirst
- ☐ excessive urination
- ☐ cold intolerance
- ☐ heat intolerance

Hematopoietic/Lymphatic
- ☐ easy bruising
- ☐ lymph node enlargement
- ☐ bleeding problems
- ☐ frequent infections

Pulmonary
- ☐ **shortness of breath**
- ☐ cough
- ☐ sputum
- ☐ wheezing

Neurologic
- ☐ headaches
- ☐ dizziness
- ☐ blackouts
- ☐ numbness and tingling
- ☐ paralysis
- ☐ convulsions/seizures
- ☐ coordination trouble

Genitourinary
- ☐ burning on urination
- ☐ frequency of urination
- ☐ **bloody urine**
- ☐ sexual difficulties

Cardiovascular
- ☐ **chest pain**
- ☐ palpitations (irregular heart beat)
- ☐ heart failure
- ☐ edema (leg swelling)
- ☐ syncope (passing out)

Gastrointestinal
- ☐ heartburn/indigestion
- ☐ ulcers
- ☐ nausea/vomiting
- ☐ hemorrhoids
- ☐ rectal bleeding or **black bowel movements**
- ☐ jaundice or hepatitis

Musculoskeletal
- ☐ joint pain
- ☐ joint swelling or warmth
- ☐ joint stiffness
- ☐ muscle pain
- ☐ weakness
- ☐ back pain

Psychiatric
- ☐ anxiety
- ☐ depression
- ☐ has seen/is seeing a psychiatrist

_____ _____
(Patient initials) (Date)

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We would like to better understand your condition. If you have prolapse or incontinence, please answer the following questions. If not, please skip the next 3 pages.

New Patient	3 months	6 months	12 months	24 months	36 months	60 Months

Pelvic Floor Distress Inventory (PFDI-20)

Patient Name:_____

Date:_____ DOB_____

Pelvic Organ Prolapse Distress Inventory 6 POPDI-6	**NO**	If yes, how much does it bother you?			
		Not at all	**Somewhat**	**Moderately**	**Greatly**
Do you usually experience pressure in the lower abdomen?	0	1	2	3	4
Do you usually experience heaviness or dullness in pelvic area?	0	1	2	3	4
Do you usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1	2	3	4
Do you ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1	2	3	4
Do you usually experience a feeling of incomplete bladder emptying?	0	1	2	3	4
Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1	2	3	4

Colorectal-Anal Distress Inventory 8 (CRADI-8)

Do you feel you need to strain too hard to have a bowel movement?	NO	Not at all	Somewhat	Moderately	Greatly
Do you feel you have not completely emptied your bowels at the end of a bowel movement?	0	1	2	3	4
Do you usually lose stool beyond your control if your stool is well formed?	0	1	2	3	4
Do you usually lose stool beyond your control if your stool is loose?	0	1	2	3	4
Do you usually lose gas from the rectum beyond your control?	0	1	2	3	4
Do you usually have pain when you pass stool?	0	1	2	3	4
Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1	2	3	4
Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1	2	3	4

Urinary Distress Inventory 6 (UDI-6)

Do you usually experience frequent urination?	No	Not at all	Somewhat	Moderately	Greatly
Do you usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of need to go to the bathroom?	0	1	2	3	4
Do you usually experience urine leakage related to coughing, sneezing, and laughing?	0	1	2	3	4
Do you usually experience small amounts of urine leakage (that is, drops?)	0	1	2	3	4
Do you usually experience difficulty emptying your bladder?	0	1	2	3	4
Do you usually experience pain or discomfort in the lower abdomen or genital region?	0	1	2	3	4

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New Patient	3 months	6 months	12 months	24 months	36 months	60 Months

Pelvic Floor Impact Questionnaire-short form 7

How do the following symptoms or conditions affect your ability to do the following actions and activities?	Bladder/Urine	Bowel/Rectum	Vagina/Pelvis
Ability to do household chores (cooking, housecleaning, laundry)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
Ability to do physical 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
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
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
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
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
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

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New Patient	3 months	6 months	12 months	24 months	36 months	60 Months

Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire (PISQ-12)

Following are a list of questions about you and your partner's sex life. All information is strictly confidential. Your confidential answered 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.

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.
   ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

2. Do you climax (have an orgasm) when having sexual intercourse 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

10. Does your partner have a problem with erections that affects your sexual activity?
    ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

11. 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?
    ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

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We would like to better understand your condition. If you have fecal incontinence please answer the following questions.

New Patient	3 months	6 months	12 months	24 months	36 months	60 Months

Fecal Incontinence Severity Index (FISI)
For each of the following, please indicate on average how often in the past month you experience any amount of accidental bowel leakage (Check only one box per row)

Type of Fecal Incontinence	2 or more times a day	Once a day	Once a week	1 to 3 times per month	Never
Gas					
Mucus					
Liquid Stool					
Solid Stool					

Wexner Constipation Questionnaire

1. **Evacuation frequency**
   a. **1-2 times per day**
   b. **2 times per week**
   c. **1 time per week**
   d. **<1 time per week**
   e. **<1 time per month**

2. **Time necessary to evacuate (in minutes)**
   a. **<5**
   b. **5-10**
   c. **10-20**
   d. **20-30**
   e. **>30**

3. **Difficulties in evacuation**
   a. **Never**
   b. **Rarely**
   c. **Sometimes**
   d. **Usually**
   e. **Always**

4. **Duration of constipation (in years)**
   a. **0**
   b. **1-5**
   c. **5-10**
   d. **10-20**
   e. **>20**

5. **Incomplete evacuation**
   a. **Never**
   b. **Rarely**
   c. **Sometimes**
   d. **Usually**
   e. **Always**

6. **Abdominal pain**
   a. **Never**
   b. **Rarely**
   c. **Sometimes**
   d. **Usually**
   e. **Always**