## Urogynecology & Pelvic Floor Disorders

CARILIONCLINIC

Sarah K. Evans, MD
W. Jerod Greer, MD
Natalie E. Karp, MD
Vicki Fitzpatrick, PA
Ranessa Gibson, DPT
Laura Thomas, DPT

Dear:_____,

Thank you for contacting the Carilion Clinic Urogynecology Clinic. Your appointment is scheduled with:

**W. Jerod Greer, MD** **Sarah K. Evans, MD**
**Natalie E. Karp, MD**
**Vicki Fitzpatrick, PA**

on:_____ at_____A.M. P.M.

Your initial visit will last about one hour and will include a pelvic exam.

To assist in your case, enclosed please find:

1. Map to our clinic
2. Facility parking information
3. Patient registration forms
2. Medical history questionnaires
3. Bladder diary (3-day diary to be completed ***PRIOR*** to your visit with us)

To ensure you receive the best possible care, please complete the above forms and bladder diary and bring the completed paperwork and diary with you to your first visit. It is important that you complete all the forms mailed to you prior to your first visit.

Please plan to arrive 15 minutes before your scheduled appointment time to allow time for check-in. If you cannot keep your appointment, we ask that you please call our office 48 hours in advance, allowing us to schedule that time for another patient. Our office telephone hours are Monday-Friday, 8:00 am - 4:30 pm. Any calls received in our office after 4:00 pm may not be returned until the next business day.

Remember to bring your insurance card and co-pay to your appointment. Our office files a variety of insurances and it is not feasible for us to determine what services your particular policy covers. Please contact your insurance company regarding covered services. If your insurance requires a referral to see a specialist, please contact your primary care physician to complete a referral and ask them to fax the referral to our office prior to your visit with us.

As surgeons, our office schedule may sometimes be interrupted by patients requiring immediate care. To provide you with continuity of care, our medical staff includes a physician's assistant who may see you in our absence.

We look forward to seeing you!

CARILION CLINIC

# PATIENT INFORMATION

| | | |
|---|---|---|
| **NAME:** (Last) (First) (Middle) | | |
| **MAILING ADDRESS** _____ (Street Number and Street Name or PO) _____ (City) (State) (Zip) | **HOME PHONE:** (____) _____ **ALTERNATE PHONE:** (____) _____ | **CELL PHONE:** (____) _____ |
| Which telephone numbers may we call you at? Home Mobile Work<br>Which telephone numbers may we leave messages? Home Mobile Work | | |
| **SOCIAL SECURITY NUMBER:** | **BIRTH DATE:** | **MARITAL STATUS:** |
| **EMPLOYER NAME:** | **EMPLOYER ADDRESS:** | **EMPLOYER PHONE:** ( ) ____ - _____ EXTENSION: _____ |
| **EMERGENCY CONTACT NAME:** _____ **RELATIONSHIP: Spouse Child Parent Friend Other** | | **Emergency Contact Phone:** ( ) ____ - _____ |
| **Which pharmacy would you like us to use for you?** | | |

# INSURANCE and SUBSCRIBER'S EMPLOYER INFORMATION

| | | | |
|---|---|---|---|
| **PRIMARY INSURANCE:** _____ **POLICY ID:** _____ **GROUP NUMBER:** _____ **RELATIONSHIP TO PATIENT:** SELF SPOUSE PARENT | **SUBSCRIBER'S NAME:** _____ **SUBSCRIBER'S DATE OF BIRTH:** _____ **SUBSCRIBER'S SOCIAL:** _____ **SUBSCRIBER'S ADDRESS:** _____ **SUBSCRIBER'S PHONE:** ( ) ____ - _____ | **SUBSCRIBER'S EMPLOYER:** _____ **SUBSCRIBER'S EMPLOYER'S ADDRESS:** _____ **SUBSCRIBER'S EMPLOYER'S PHONE:** ( ) ____ - _____ | **Circle one:** Full Time Or Part Time |
| **SECONDARY INSURANCE:** _____ **POLICY ID:** _____ **GROUP NUMBER:** _____ **RELATIONSHIP TO PATIENT:** SELF SPOUSE PARENT | **SUBSCRIBER'S NAME:** _____ **SUBSCRIBER'S DATE OF BIRTH:** _____ **SUBSCRIBER'S SOCIAL:** _____ **SUBSCRIBER'S ADDRESS:** _____ **SUBSCRIBER'S PHONE:** ( ) ____ - _____ | **SUBSCRIBER'S EMPLOYER:** _____ **SUBSCRIBER'S EMPLOYER'S ADDRESS:** _____ **SUBSCRIBER'S EMPLOYER'S PHONE:** ( ) ____ - _____ | **Circle one:** Full Time Or Part Time |

OFFICE USE ONLY

Site Code: UGYNE
Doc Type: PATIE
MPI #: _____

Name: _____ Date: __ / __ / ____

| **What is the reason for your visit?** | |
|---|---|
| | |
| | |
| | |
| When did this start? _____ | Rate symptom severity (1-10) _____ |

| **What treatments have you tried?** (Kegel exercises, medications, surgery, etc...) |
|---|
| |
| |
| |
| ☐ Detrol ☐ Ditropan ☐ Oxytrol ☐ Enablex ☐ Vesicare ☐ Sanctura ☐ Flomax ☐ Cardura ☐ DDAVP ☐ Other _____ |

| **SUPPORT PROBLEMS** | | Please consider your symptoms over the **past 3 months.** |
|---|---|---|
| Do you usually experience pressure in the lower abdomen? | ☐ NO | ☐ YES<br>How bothersome is that symptom for you?<br>☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit |
| Do you usually experience heaviness or dullness in the pelvic area? | ☐ NO | ☐ YES<br>How bothersome is that symptom for you?<br>☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit |
| Do you usually have a bulge or something falling out that you can see or feel in your vaginal area? | ☐ NO | ☐ YES<br>How bothersome is that symptom for you?<br>☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit |
| Do you ever have to push on the vagina or around the rectum to have or complete a bowel movement? | ☐ NO | ☐ YES<br>How bothersome is that symptom for you?<br>☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit |
| Do you usually experience a feeling of incomplete bladder emptying? | ☐ NO | ☐ YES<br>How bothersome is that symptom for you?<br>☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit |
| Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination? | ☐ NO | ☐ YES<br>How bothersome is that symptom for you?<br>☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit |

| **URINARY PROBLEMS** | | |
|---|---|---|
| How frequently do you urinate during the day? | Every ___ hours | |
| How many times do you get up at night to urinate? | ____ times | |
| Have you had 3 or more urinary tract infections in the past year? | ☐ YES | ☐ NO |
| Have you seen blood in your urine in the past 12 months? | ☐ YES | ☐ NO |

| **On an average day how much do you drink? List below.** | | | |
|---|---|---|---|
| **Type of Fluid** (coffee) | **Amount** (cups, etc) | **Type of Fluid** (coffee) | **Amount** (cups, etc) |
| | | | |
| | | | |

Name: _____ Date: __ / __ / ____

| **URINARY PROBLEMS (cont'd)** | | | | |
|---|---|---|---|---|
| Please circle your **best response** to the following questions: | | | | |
| Does coughing gently cause you to lose urine? | Never | Rarely | Sometimes | Often |
| Does coughing hard cause you to lose urine? | Never | Rarely | Sometimes | Often |
| Does sneezing cause you to lose urine? | Never | Rarely | Sometimes | Often |
| Does lifting things cause you to lose urine? | Never | Rarely | Sometimes | Often |
| Does bending cause you to lose urine? | Never | Rarely | Sometimes | Often |
| Does laughing cause you to lose urine? | Never | Rarely | Sometimes | Often |
| Does walking briskly or jogging cause you to lose urine? | Never | Rarely | Sometimes | Often |
| Does straining, if you are constipated, cause you to lose urine? | Never | Rarely | Sometimes | Often |
| Does getting up from a sitting to a standing position cause you to lose urine? | Never | Rarely | Sometimes | Often |
| | | | | |
| Some women receive very little warning but suddenly find that they are losing or about to lose urine beyond their control. How often does this happen to you? | Never | Rarely | Sometimes | Often |
| 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? | Never | Rarely | Sometimes | Often |
| Do you lose urine when you suddenly have the feeling that your bladder is very full? | Never | Rarely | Sometimes | Often |
| Does washing your hands cause you to lose urine | Never | Rarely | Sometimes | Often |
| Does cold weather cause you to lose urine? | Never | Rarely | Sometimes | Often |
| Does drinking cold beverages cause you to lose urine? | Never | Rarely | Sometimes | Often |
| What other things cause you to lose urine? _____ | | | | |

| **How often do you experience urine leakage?** | | | | |
|---|---|---|---|---|
| ☐ Never | ☐ Less than once a month | ☐ One or several times a month | ☐ One or several times a week | ☐ Every day and/or night |

| **How much urine do you lose each time?** | | |
|---|---|---|
| ☐ Drops | ☐ Small splashes | ☐ More |

**If pain is present, rate pain on a 1-10 scale, 10 being the worst.** _____

Name: _____ Date: __ / __ / ____

**BOWEL PROBLEMS:** For each of the following, please indicate on average how often in the **past month** you experienced any amount of **ACCIDENTAL** bowel leakage: (Check one box per row)

| | 2 or More Times a Day | Once a Day | 2 or More Times a Week | Once a Week | 1 to 3 Times a Month | Never |
|---|---|---|---|---|---|---|
| Gas | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mucus | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Liquid Stool | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Solid Stool | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you have constipation? | ☐ YES | ☐ No | How frequently do you have bowel movements? _____ | | | |

| **IMPACT ON YOUR LIFE** | ***Please rate the severity of your*** | | |
|---|---|---|---|
| How do symptoms or conditions relate to the following ⇒⇒⇒⇒ Usually affect your ⇓⇓⇓⇓ | ***Bladder or urine*** | ***Bowel or rectum*** | ***Vagina or pelvis*** |
| 1. Ability to do household chores (cooking, housecleaning, laundry?) | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit |
| 2. Ability to do physical activities such as walking, swimming, or other exercise? | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit |
| 3. Entertainment activities such as going to a movie or concert? | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit |
| 4. Ability to travel by car or bus for a distance greater than 30 minutes away from home? | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit |
| 5. Participating in social activities outside your home? | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit |
| 6. Emotional health (nervousness, depression, etc)? | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit |
| 7. Feeling frustrated? | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit | ☐ Not at all<br>☐ Somewhat<br>☐ Moderately<br>☐ Quite a bit |

Name: _____ Date: __ / __ / ____

| OBSTETRICAL HISTORY | |
|---|---|
| How many times have you been pregnant? | ___ Times |
| How many children did you deliver? | ___ Natural birth(s) ___ C-Section(s) |
| How big was your biggest baby? | ___ lbs ___ oz |
| Did you have any problems with the deliveries? (large tears, bleeding, etc.) | |

| WOMEN'S HEALTH HISTORY | | |
|---|---|---|
| Have you experienced MENOPAUSE (natural or surgical)? | ☐ YES (Age: _ yrs) | ☐ NO (Last period: _/_/_) Problems with periods? _____ |
| Do you take any HORMONES (pills, creams, patch, etc)? | ☐ YES Describe: _____ | ☐ NO |
| Are you sexually active? | ☐ YES | ☐ NO |
| Is sexual intercourse painful for you? | ☐ YES | ☐ NO |
| Have you ever been sexually or physically abused? | ☐ YES | ☐ NO |
| Have you ever had an abnormal PAP smear? | ☐ YES | ☐ NO |
| Have you ever had an abnormal colon screen? | ☐ YES | ☐ NO |

| GENERAL MEDICAL HISTORY | | | |
|---|---|---|---|
| **Heart Problems** | **Lung Problems** | **Bowel Problems** | **Neurologic Problems** |
| ☐ Heart disease | ☐ Asthma | ☐ Bowel disease | ☐ Stroke |
| ☐ High blood pressure | ☐ Recent pneumonia | ☐ Ulcers | ☐ Multiple Sclerosis |
| ☐ Heart murmur | ☐ COPD/Emphysema | ☐ Diverticulitis | ☐ Back injury or surgery |
| ☐ Heart attack | | ☐ Liver disease (_____) | |
| **Endocrine Problems** | **Bleeding Problems** | **Other** | |
| ☐ Diabetes | ☐ Bleeding problem | ☐ Kidney Disease | ☐ _____ |
| ☐ Thyroid disease | ☐ Blood clot problem | ☐ Glaucoma | ☐ _____ |
| ☐ Osteoporosis | ☐ Aspirin or Plavix use | ☐ Cancer | ☐ _____ |
| ☐ Chronic steroid use | ☐ Coumadin Use | ☐ _____ | ☐ _____ |

| Please tell us more about anything that was checked above, or about any other problems: |
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Name: _____ Date: __ / __ / ____

| SURGICAL HISTORY (Be sure to include ALL bladder and/or gynecologic surgery) | | | |
|---|---|---|---|
| **Operation** | **Date** | **Surgeon** | **Hospital** |
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| MEDICATIONS (including over the counter medications) | | | |
|---|---|---|---|
| **Medicine** | **Dose** | **Medicine** | **Dose** |
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| ALLERGIES (Please include reaction) ☐ I do not have any allergies |
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| FAMILY HISTORY | | | Family Member(s) | Age of Onset |
|---|---|---|---|---|
| Breast Cancer | ☐ YES | ☐ NO | | |
| Colon Cancer | ☐ YES | ☐ NO | | |
| Ovarian Cancer | ☐ YES | ☐ NO | | |
| Uterine Cancer | ☐ YES | ☐ NO | | |
| Other Cancer | ☐ YES | ☐ NO | | |
| Heart Disease | ☐ YES | ☐ NO | | |
| Diabetes | ☐ YES | ☐ NO | | |
| High blood pressure | ☐ YES | ☐ NO | | |
| Osteoporosis | ☐ YES | ☐ NO | | |
| Urinary Incontinence | ☐ YES | ☐ NO | | |

| | |
|---|---|
| Your **Primary Care** provider: | City, State: |
| Provider who **referred** you: | City, State: |

Name: _____ Date: __ / __ / ____

| DAILY LIFE | | |
|---|---|---|
| What kind of work do you do? | | |
| Who is your main support person? | | |
| Do you consider yourself healthy? | ☐ YES | ☐ NO |
| Do you currently smoke? | ☐ YES | ☐ NO |
| Have you ever smoked? | ☐ YES<br>Starting age? ___ Ending age? ___ Packs per day? ___ | ☐ NO |
| How many glasses of beer, wine, or alcohol do you drink every week? _____ | | |
| Activity/Exercise? ☐ None ☐ 1-2 days/week ☐ 3-4 days/week ☐ 5+ days/week | | |

| Do you *currently* have any of the following symptoms? | | |
|---|---|---|
| **Constitutional** | **Cardiovascular** | **Neurological** |
| ☐ Fever | ☐ Chest pain | ☐ Dizziness |
| ☐ Chills | ☐ Palpitations | ☐ Tingling |
| ☐ Weight loss | ☐ Shortness of Breath when lying down | ☐ Tremor |
| ☐ Fatigue | ☐ Leg pain with exercise | ☐ Sensory changes |
| ☐ Excessive sweating | ☐ Leg swelling | ☐ Speech change |
| ☐ Weakness | | ☐ Weakness to one area of body |
| | **Gastrointestinal** | ☐ Seizures |
| **Skin** | ☐ Heartburn | ☐ Fainting spells |
| ☐ Rash | ☐ Nausea | |
| ☐ Itching | ☐ Vomiting | **Psychiatric** |
| | ☐ Abdominal pain | ☐ Depression |
| **Head, Ears, Nose & Throat** | ☐ Diarrhea | ☐ Suicidal ideas |
| ☐ Headaches | ☐ Constipation | ☐ Substance abuse |
| ☐ Hearing Loss | ☐ Blood in stool | ☐ Hallucinations |
| ☐ Ringing in the ears | ☐ Black, tarry stools | ☐ Anxiety |
| ☐ Ear pain | | ☐ Inability to sleep |
| ☐ Ear discharge | **Muscles and Joints** | ☐ Memory loss |
| ☐ Nosebleeds | ☐ Muscle pain | ☐ Physical or sexual abuse |
| ☐ Congestion | ☐ Neck pain | |
| ☐ Sore throat | ☐ Back pain | **Respiratory** |
| | ☐ Joint pain | ☐ Cough |
| **Eyes** | ☐ Falls | ☐ Coughing up blood |
| ☐ Blurred vision | | ☐ Sputum production |
| ☐ Double vision | **Endocrine or Allergy** | ☐ Shortness of breath |
| ☐ Light sensitivity | ☐ Easy bruising or bleeding | ☐ Wheezing |
| ☐ Eye pain | ☐ Environmental allergies | |
| ☐ Eye discharge | ☐ Excessive thirst | |
| ☐ Eye redness | | |

**Finally, what are your treatment goals?** _____

# BLADDER DIARY

It is very important to us that we completely understand your bladder symptoms. Our goal is that your bladder symptoms will improve! This bladder diary is one of *the most important parts* of our evaluation of your symptoms.

Please fill out this 3-day bladder diary and bring it with you to your next appointment at Carilion Urogynecology.

General Instructions:

1. Start first thing in the morning! Begin a new page every morning.
2. Record the time of day for each time you urinate in the toilet, and the time of day for each time you have accidental urine leakage. If you have leakage on the way to the bathroom, just write the time in the first column and put a check mark (√) in the "Accidental Leaks" column.
3. If a leakage episode is related to cough, sneeze, or physical activity, and is not associated with an urge, please write "Stress" in the Notes section.
4. Urgency rating: 0 = None, 1 = Mild, 2 = Moderate, 3 = Severe
5. Amount leaked: 1 = Small accident, 2 = Medium accident, 3 = Large accident
6. Record the total number of pads and diapers used during the 24-hour day at the bottom of the page.

Please call us if you have questions (540) 985-4099

Name: _____ Date: __ / __ / ____

# Day #1

**Wake Time: _____** **Bed Time: _____**

**Name: _____** **Date: _____**

| **Time → Urinated in Toilet** | **Time → Accidental Leaks** | **Urgency Rating** (0 - 3) | **Amount Leaked** (1 - 3) | **Activity With Leakage** (What you were doing when leaks happened) |
|---|---|---|---|---|
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**Number of Pads or Diapers Today: ___**

Name: _____ Date: __ / __ / ____

# Day #2

**Wake Time: _____** **Bed Time: _____**

**Name: _____** **Date: _____**

| **Time → Urinated in Toilet** | **Time → Accidental Leaks** | **Urgency Rating** (0 - 3) | **Amount Leaked** (1 - 3) | **Activity With Leakage** (What you were doing when leaks happened) |
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**Number of Pads or Diapers Today: ___**

Name: _____ Date: __ / __ / ____

# Day #3

**Wake Time: _____** **Bed Time: _____**

**Name: _____** **Date: _____**

| **Time → Urinated in Toilet** | **Time → Accidental Leaks** | **Urgency Rating** (0 - 3) | **Amount Leaked** (1 - 3) | **Activity With Leakage** (What you were doing when leaks happened) |
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**Number of Pads or Diapers Today: ___**

**DON'T FORGET TO BRING YOUR DIARY WITH YOU!!!**