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WMED HEALTH

Welcome!

Division of Urogynecology
Female Pelvic Medicine and Reconstructive Surgery

We would like to welcome you to our office! We are happy to provide care for your urogynecologic concerns, and would like to take a moment to provide you with a few details prior to your appointment.

Included in this packet you will find information regarding your upcoming appointment, a map and questionnaire. To help your visit go smoothly, please bring the completed questionnaire and all other requested information.

What is a Urogynecologist?
Although your primary care physician, Ob/Gyn, or Urologist may have knowledge about these problems, a Urogynecologist may offer additional expertise. You should be referred to a Urogynecologist when you have problems with pelvic organ prolapse, troublesome urinary or fecal incontinence, or when your primary doctor recommends consultation.

What Kind of Training Does a Urogynecologist Have?
Urogynecologists are physicians who have completed medical school and a residency in either Ob/Gyn or Urology. These physicians become specialists with additional years of fellowship training and board certification in Female Pelvic Medicine and Reconstructive Surgery.

What Treatment Options are Available from a Urogynecologist?
A Urogynecologist can recommend a variety of therapies to cure or relieve symptoms of pelvic floor disorders. You should choose the one that works best for your lifestyle and meets your goals.

Melinda Abernethy, MPH, MD, FACOG

Christiana Palma, MS, PA-C

We look forward to meeting you!

Urogynecology New Patient Medical History

Patient name:_____ DOB:_____ Today's date:_____

What is your identified race/ethnicity?_____

What is the nature of your current pelvic floor problem?_____

_____

_____

Preferred pharmacy location & phone:_____

Referring physician:_____ Primary care physician:_____

MEDICATIONS

List any drug allergies:_____

Current medications (including dosage):_____

_____

MEDICAL HISTORY

✓ to indicate medical history of the following:

___ Heart disease	___ High blood pressure	___ Heart murmur
___ Asthma	___ Tuberculosis	___ Pneumonia
___ Kidney disease	___ Kidney infection	___ Bladder infection
___ Thyroid disease	___ Diabetes	___ Low blood count (anemia)
___ Constipation	___ Bowel disease	___ Liver disease
___ Parkinson's	___ Multiple Sclerosis (MS)	___ Stroke
___ Serious injuries	___ Arthritis	___ Migraines
___ Depression	___ Anxiety	___ Paralysis
___ Cancer	Other, list:_____	

SURGICAL HISTORY & CANCER SCREENING

If you have had any open operations, please list them here:

Surgery	Date	Surgeon

Date of last pap smear:_____ Normal/Abnormal Any history of abnormal pap?_____

Date of last mammogram:_____ Normal/Abnormal

Date of last colonoscopy:_____ Normal/Abnormal

OBSTETRICAL HISTORY:

Number of pregnancies:_____Number of children:_____Number of C-sections: ___

Weight of largest infant:_____

During delivery, did you have an episiotomy or vaginal tear? Yes/No

During delivery, did you have a tear in the rectum? Yes/No

During delivery, were forceps or a vacuum used? Yes/No

GYNECOLOGICAL HISTORY:

Date of last menstrual period: _____

Have you ever had a hysterectomy? Yes/No

Have you had one or both ovaries removed? Yes/No

Do you take hormone replacement therapy? Yes/No

Have you had irregular or abnormal uterine bleeding? Yes/No

Are you currently sexually active? Yes/No

If yes, is your sex life satisfactory for you? Yes/No

If yes, do you have pain with intercourse? Yes/No

Is your partner male or female? _____

SOCIAL HISTORY:

Please describe your tobacco use (please pick one): _____Never _____Past _____Present

If you have smoked cigarettes please list: Number of packs/day _____ Years smoking_____

Do you drink alcoholic beverages? _____Yes _____No If yes, how many alcoholic drinks per week? _____

Please indicate your highest level of education (please pick one):

___ Elementary school ___ Jr. high school ___ High school

___ College degree ___ Graduate degree ___ Decline to answer

FAMILY HISTORY:

Does anyone in your family have any of the following? (If so, please provide relationship)

___ Breast cancer ___ Ovarian cancer ___ Uterine cancer ___ Colon cancer

___ High blood pressure ___ Diabetes ___ Heart disease ___ Stroke

Other, list: _____

REVIEW OF SYSTEMS:

✓ If you are currently experiencing:

___ Fatigue ___ Weight loss ___ Weight gain ___ Fever

___ Glaucoma ___ Hearing loss ___ Nose or gum bleeds ___ Sinus problems

___ Chest pain ___ Palpitations ___ Shortness of breath ___ Feet swelling

___ Coughing ___ Coughing blood ___ Wheezing/asthma ___ Passing out

___ Constipation ___ Diarrhea ___ Bloody stool ___ Bowel changes

___ Nausea/vomiting ___ Loss of appetite ___ Difficulty swallowing ___ Anemia

___ Bleeding/bruising ___ Swollen glands ___ Rash/itching ___ Breast mass

___ Nipple discharge ___ Breast pain ___ Headache ___ Dizziness

___ Seizures ___ Numbness/tingling ___ Weakness ___ Joint pain

___ Muscle pain ___ Back pain ___ Depression ___ Anxiety

___ Heat/cold intolerance ___ Excessive thirst ___ Excessive urination ___ Hot flashes

___ Difficulty sleeping ___ Steroid use ___ Difficulty healing ___ Blood in urine

BLADDER AND BOWEL SYMPTOMS:

On average, how many times do you:

Urinate during waking hours? _____

Get up from sleep to urinate? _____

On average, how many bowel movements do you have per week? _____

Do you use pads for any of the following reasons besides period protection?

_____Urinary leakage _____Stool leakage Other: _____

If you use pads for leakage, what type of pads do you use?

_____None _____ Minipad _____ Shield _____ Diaper

How many do you use in a 24 hour period? _____

Pelvic Floor Distress Inventory (PFDI 20)

Patient name:_____ DOB:_____ Today's date:_____

PFDI- 20 Instructions: 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 these by circling the appropriate number. While answering these questions, please consider your symptoms over the ***last 3 months***.

Symptoms Not Present = NO
Symptoms Present = YES, scale of bother:
0 = not present (never experienced)
1 = not at all (experienced previously)
2 = somewhat
3 = moderately
4 = quite a bit

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)

Do you…	No	Yes
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
6. 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 (CRAD-8):

Do you…	No	Yes
7. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
9. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
10. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
11. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
12. Usually have pain when you pass your stool?	0	1 2 3 4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
14. 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…	No	Yes
15. Usually experience frequent urination?	0	1 2 3 4
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	1 2 3 4
17. Usually experience urine leakage related to coughing, sneezing, or laughing?	0	1 2 3 4
18. Usually experience small amounts of urine leakage (that is, drops)?	0	1 2 3 4
19. Usually experience difficulty emptying your bladder?	0	1 2 3 4
20. Usually experience *pain* or *discomfort* in the lower abdomen or genital region?	0	1 2 3 4

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Pelvic Floor Impact Questionnaire (PFIQ-7)

Patient name:_____ DOB:_____ Today's date:_____

PFIQ – 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, or feelings have been affected by your bladder, bowel, or vaginal symptoms or conditions over the past 3 months. Please make sure you mark an answer in all 3 columns for each question.

How do symptoms or conditions relating to the following → → → usually affect your… ↓	Bladder or urine	Bowel or rectum	Vagina or pelvis
1. Ability to do household chores (cooking, cleaning, 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
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

Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire

Patient name:_____ DOB:_____ Today's date:_____

Instructions: Following is a list of questions about you and your partner's sex life. All information is strictly confidential. Please circle the answer that best describes your symptoms over the past six months.

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.
   Daily Weekly Monthly Less than Once a Month 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 your 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?
    Much less intense Less intense Same Intensity More intense Much more intense

WMED HEALTH

THE CLINICAL PRACTICE OF WESTERN MICHIGAN UNIVERSITY
HOMER STRYKER M.D. SCHOOL OF MEDICINE

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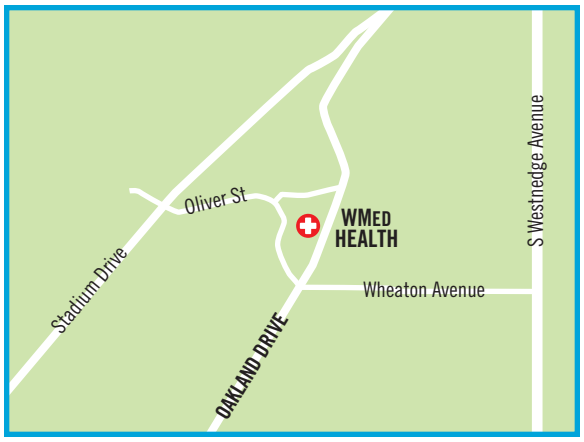
From the North or South

- Take US-131 to the exit for Stadium Drive East (Exit 36A toward downtown Kalamazoo).
- Take Stadium Drive to Howard Street and turn right onto Howard Street.
- At the top of the hill, there is a traffic light—turn left onto Oakland Drive at that light.
- Continue on Oakland Drive, passing the Kalamazoo Psychiatric Hospital (on your left).
- WMed Health will be located on your left, past the traffic light at Wheaton Avenue.

From the East or West

- Take I-94 to the Oakland Drive exit.
- Turn North onto Oakland Drive and continue for approximately 3.3 miles.
- WMed Health will be located on your left, past the Kalamazoo Psychiatric Hospital and the traffic light at Wheaton Avenue.



670 MALL DRIVE

PORTAGE, MICHIGAN 49024

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From the North or South

- Take US-131 to I-94 East toward Detroit (Exit 34).
- Take Exit 75 onto Oakland Drive. Turn South (right) and continue for approximately .5 miles.
- Turn East (left) onto W. Milham Avenue and continue for approximately .6 miles.
- Just past the US Post Office, turn South (right) onto Constitution Boulevard and continue for approximately .4 miles.
- Turn East (left) onto Mall Drive. WMed Health will be on your left.

From the East or West

- Take I-94 to the Westnedge Avenue exit (Exit 76).
- Turn South onto Westnedge Avenue and continue for approximately .8 miles.
- Turn West (right) onto Mall Drive and continue for approximately .5 miles.
- WMed Health will be on your right.