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:

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Date</th>
<th>Surgeon</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

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

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**Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6):**

<table>
<thead>
<tr>
<th>Do you…</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Usually experience pressure in the lower abdomen?</td>
<td>0</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>2. Usually experience heaviness or dullness in the pelvic area?</td>
<td>0</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?</td>
<td>0</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?</td>
<td>0</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>5. Usually experience a feeling of incomplete bladder emptying?</td>
<td>0</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?</td>
<td>0</td>
<td>1 2 3 4</td>
</tr>
</tbody>
</table>

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**Colorectal-Anal Distress Inventory 8 (CRAD-8):**

<table>
<thead>
<tr>
<th>Do you…</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Feel you need to strain too hard to have a bowel movement?</td>
<td>0</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>8. Feel you have not completely emptied your bowels at the end of a bowel movement?</td>
<td>0</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>9. Usually lose stool beyond your control if your stool is well formed?</td>
<td>0</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>10. Usually lose stool beyond your control if your stool is loose?</td>
<td>0</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>11. Usually lose gas from the rectum beyond your control?</td>
<td>0</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>12. Usually have pain when you pass your stool?</td>
<td>0</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?</td>
<td>0</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?</td>
<td>0</td>
<td>1 2 3 4</td>
</tr>
</tbody>
</table>

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**Urinary Distress Inventory 6 (UDI-6):**

<table>
<thead>
<tr>
<th>Do you…</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Usually experience frequent urination?</td>
<td>0</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?</td>
<td>0</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>17. Usually experience urine leakage related to coughing, sneezing, or laughing?</td>
<td>0</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>18. Usually experience small amounts of urine leakage (that is, drops)?</td>
<td>0</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>19. Usually experience difficulty emptying your bladder?</td>
<td>0</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>20. Usually experience pain or discomfort in the lower abdomen or genital region?</td>
<td>0</td>
<td>1 2 3 4</td>
</tr>
</tbody>
</table>

Revised: 07/21/21
## 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... ↓

<table>
<thead>
<tr>
<th>Question</th>
<th>Bladder or urine</th>
<th>Bowel or rectum</th>
<th>Vagina or pelvis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ability to do household chores (cooking, cleaning, laundry)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Not at all</td>
<td>□ Not at all</td>
<td>□ Not at all</td>
<td></td>
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<tr>
<td>□ Somewhat</td>
<td>□ Somewhat</td>
<td>□ Somewhat</td>
<td></td>
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<tr>
<td>□ Moderately</td>
<td>□ Moderately</td>
<td>□ Moderately</td>
<td></td>
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<tr>
<td>□ Quite a bit</td>
<td>□ Quite a bit</td>
<td>□ Quite a bit</td>
<td></td>
</tr>
<tr>
<td>2. Ability to do physical activities such as walking, swimming, or other exercise?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Not at all</td>
<td>□ Not at all</td>
<td>□ Not at all</td>
<td></td>
</tr>
<tr>
<td>□ Somewhat</td>
<td>□ Somewhat</td>
<td>□ Somewhat</td>
<td></td>
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<tr>
<td>□ Moderately</td>
<td>□ Moderately</td>
<td>□ Moderately</td>
<td></td>
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<tr>
<td>□ Quite a bit</td>
<td>□ Quite a bit</td>
<td>□ Quite a bit</td>
<td></td>
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<tr>
<td>3. Entertainment activities such as going to a movie or concert?</td>
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<td></td>
<td></td>
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<tr>
<td>□ Not at all</td>
<td>□ Not at all</td>
<td>□ Not at all</td>
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<td>□ Somewhat</td>
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<td>□ Moderately</td>
<td>□ Moderately</td>
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<td>□ Quite a bit</td>
<td>□ Quite a bit</td>
<td>□ Quite a bit</td>
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<tr>
<td>4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?</td>
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<tr>
<td>□ Not at all</td>
<td>□ Not at all</td>
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<td>□ Somewhat</td>
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<td>□ Moderately</td>
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<td>□ Moderately</td>
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<tr>
<td>□ Quite a bit</td>
<td>□ Quite a bit</td>
<td>□ Quite a bit</td>
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<tr>
<td>5. Participating in social activities outside your home?</td>
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<tr>
<td>□ Not at all</td>
<td>□ Not at all</td>
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<tr>
<td>□ Quite a bit</td>
<td>□ Quite a bit</td>
<td>□ Quite a bit</td>
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<tr>
<td>6. Emotional health (nervousness, depression, etc.)</td>
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<td>□ Not at all</td>
<td>□ Not at all</td>
<td>□ Not at all</td>
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<td>□ Somewhat</td>
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<td>□ Moderately</td>
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<td>□ Quite a bit</td>
<td>□ Quite a bit</td>
<td>□ Quite a bit</td>
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<tr>
<td>7. Feeling frustrated?</td>
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<td>□ Not at all</td>
<td>□ Not at all</td>
<td>□ Not at all</td>
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<td>□ Somewhat</td>
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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 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?
    - Much less intense
    - Less intense
    - Same Intensity
    - More intense
    - Much more intense
1000 OAKLAND DRIVE
KALAMAZOO, MICHIGAN 49008
269.337.4600 · patientinquiries@med.wmich.edu

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
269.327.1900 · patientinquiries@med.wmich.edu

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.