Beth Israel Lahey Health
Mount Auburn Hospital

Boston Urogynecology Associates

725 Concord Avenue, Suite 3500, Cambridge MA 02138
Phone: 617-354-5452 Fax: 617-497-7503

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

Anthony DiSciullo, M.D. Eman Elkadry, M.D. Peter Rosenblatt, M.D. William Winkelman, MD

Patient Registration Instructions: Please complete the following information prior to your appointment and return in the envelope provided

Name:____ Date of birth: ______________

Address: _______________________________________ Apt #: __________________________

City: ___________________________________ State: _______________ Zip: _______________

Social Security Number: ____

Home Phone: ____________________________ Work Phone: _____________________________

Cell Phone: _____________________________ Email:_________________________________

Employer: ____

Emergency Contact

Name: ____ Phone:__________________________

Relationship: ___________________________________

Insurance Information

Subscriber: ____

ID Number: ______________________________ Group #:___________________________________

Insurance Company: ____

Address: ____

Phone Number: ____

I authorize Boston Urogynecology Associates to release any information necessary to determine benefits and to process my claim filed on my behalf to Medicare or any third party insurance listed above. I also authorize Medicare or any third party insurance to make payment directly to Boston Urogynecology Associates for services rendered to me.

Signature: ____ Date: ____________________

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We would like to send a letter or copy of your office visit to your referring physician and your primary care physician. *Please indicate which doctors you would like this information sent to by checking the appropriate boxes.* In order for the report(s) to be sent out in a timely manner, we would appreciate your supplying us with the following information:

☐ **Gynecologist**

Name:____

Address: ____

City: ____ State: _____________ Zip: _____________

Telephone: ____

☐ **Primary Care Physician**

Name:____

Address: ____

City: ____ State: _____________ Zip: _____________

Telephone: ____

☐ **Referring Provider (if different than either above)**

Name:____

Address: ____

City: ____ State: _____________ Zip: _____________

Telephone: ____

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Name:____ Date of birth: __________ | Age: _______

Who referred you to see us?:____

What is the reason for your visit today?:____

Pregnancy History:

Number of pregnancies: _________ Number of vaginal deliveries: _____ Forceps delivery? Yes ☐ No☐

Number of living children: _______ Number of c-sections: ___________ Weight of largest baby: __________

Medical history (check all that apply)

☐Heart disease ☐ Glaucoma
☐ Diabetes ☐ Blood clots in legs
☐ Asthma ☐ High blood pressure
☐ Stroke ☐ Depression
☐ Anxiety ☐ Psychiatric disorder

Surgical (check all that apply)

☐ Bladder surgery ☐ Prolapse surgery
☐ Hysterectomy ☐ Hernia surgery
☐ Abdominal?
☐ Vaginal?
☐ Laparoscopic/robotic?
☐ Ovaries removed?

Other Medical Problems:

____

____

Other Surgeries:

____

____

Medications: ☐ None *(use separate sheet if needed)*

____

____

Allergies: ☐ None

____

____

Social History: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widow

Do you work? ☐ Yes ☐ No What do you do? ____

Exercise ☐ Yes ☐ No How often: ____

Sexually active ☐ Yes ☐ No How often: ____

Tobacco use ☐ Yes ☐ No How often: ____

Alcohol use ☐ Yes ☐ No How often: ____

Caffeine ☐ Yes ☐ No How often: ____

Chemical exposure ☐ Yes ☐ No Work? Environmental?:____

Family History: *Have any of your close family members (parents, children, siblings) had the following?*

Heart disease: ___________________________________ Ovarian cancer: ___________________________

Kidney stones: ___________________________________ Breast cancer: ____________________________

Connective tissue disorders:___________________________ Endometrial cancer: _________________________

Bladder surgery: _________________________________ Bladder cancer:___________________________

Prolapse surgery: ________________________________ Other cancer: ____________________________

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Review of Systems: *Do you have any of the following problems?*

General
☐ Activity change
☐ Appetite change
☐ Chills
☐ Fatigue
☐ Fever
☐ Weight change

Ears/Nose/Mouth
☐ Congestion
☐ Dental problems
☐ Hearing loss
☐ Sore throat
☐ Dry mouth

Skin
☐ Rash
☐ Swelling

Eyes
☐ Eye pain
☐ Dry eyes

Lungs
☐ Cough
☐ Shortness of breath
☐ Wheezing

Cardiovascular
☐ Chest pain
☐ Leg swelling
☐ Palpitations

Psychiatric
☐ Confusion
☐ Depression
☐ Anxiety
☐ Sleep disturbances

Endocrine
☐ Cold intolerance
☐ Heat intolerance

Musculoskeletal
☐ Joint pain
☐ Back pain
☐ Gait problems
☐ Joint swelling
☐ Muscle pain
☐ Neck pain
☐ Neck stiffness

Menopausal symptoms
☐ Hot flashes
☐ Night sweats
☐ Vaginal dryness
☐ Decreased libido

Neurological
☐ Dizziness
☐ Headaches
☐ Lightheadedness
☐ Numbness
☐ Seizures
☐ Speech difficulty
☐ Tremors
☐ Weakness

GI
☐ Abdominal distension
☐ Abdominal pain
☐ Blood in stool
☐ Diarrhea
☐ Constipation
☐ Nausea
☐ Rectal pain
☐ Vomiting

Genitourinary system

Question	Answer	Details
Are you taking birth control?	☐ Yes ☐ No	What medication are you taking?__________
Do you have a history of abnormal pap smears?	☐ Yes ☐ No	When was your last pap smear? __________
Do you have abnormal vaginal bleeding?	☐ Yes ☐ No	How often: ____________________________
Do you have to urinate frequently?	☐ Yes ☐ No	How often: ____________________________
Do you have to rush to the bathroom?	☐ Yes ☐ No	How often: ____________________________
Do you ever leak urine after a strong urge?	☐ Yes ☐ No	How often: ____________________________
Do you have pain or burning when urinating?	☐ Yes ☐ No	How often: ____________________________
Is your urine ever bloody?	☐ Yes ☐ No	How often: ____________________________
Do you get up from sleeping to go to the bathroom?	☐ Yes ☐ No	How often: ____________________________
Do you ever lose urine while sleeping?	☐ Yes ☐ No	How often: ____________________________
Do you lose urine during sex?	☐ Yes ☐ No	How often: ____________________________
Do you dribble urine after going to the bathroom?	☐ Yes ☐ No	How often: ____________________________
Do you have trouble emptying your bladder?	☐ Yes ☐ No	How often: ____________________________
Do you wear pads for your leaking?	☐ Yes ☐ No	How many pads per day: ________________
Do you feel your pelvic organs falling out	☐ Yes ☐ No	
Do you feel anything bulging out of the vagina	☐ Yes ☐ No	
Do you feel heaviness or pressure in the vagina	☐ Yes ☐ No	
Do you ever leak or lose stool?	☐ Yes ☐ No	How often: __________________________

Do you lose urine with any of the following:
☐ Lifting ☐ Standing up ☐ Getting out of bed ☐ Laughing ☐ Sneezing ☐ Exercise ☐ Coughing

Which of the following describes your urine stream: ☐ Continuous ☐ Weak ☐ Stop and start

Which of the following describes your bowel movements: ☐ Normal ☐ Diarrhea ☐ Constipation ☐ Variable

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Part 1: Check the one number that best describes how your symptom condition is now			
☐ 1. Normal	☐ 2. Mild	☐ 3. Moderate	☐ 4. Severe

Part 2: 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. The PFDI-20 has 20 items and 3 scales of your symptoms. All items use the following format with a response scale from 0 to 4.

Symptoms Not Present = NO 0 = not present (never experienced)

Symptoms Present = YES, scale of bother: 1 = not at all (experienced previously)
2 = somewhat
3 = moderately
4 = quite a bit

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 or 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

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	2	2	3	4

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Do you…	No	Yes			
15. Usually experience frequent urination?	0	1	2	3	4
16: Usually experience urine leakage associated with 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	3	2	3	4
19. Usually experience difficulty emptying your bladder?	0	4	2	3	4
20. Usually experience *pain* or *discomfort* in the lower abdomen or genital region?	0	5	2	3	4

Part 3: 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 life. 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, 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 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

Part 4: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feelings. For each question, check 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 last 3 months.** Please make sure you mark an answer in **all 3 columns** for each question.

How do symptoms or conditions in the following usually affect your	Bladder or urine	Bowel or rectum	Vagina or pelvis
1. Ability to do household chores (cooking, laundry housecleaning)?	☐ Not at all ☐ Somewhat ☐ Moderate ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderate ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderate ☐ Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	☐ Not at all ☐ Somewhat ☐ Moderate ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderate ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderate ☐ Quite a bit
3. Entertainment activities such as going to a movie or concert?	☐ Not at all ☐ Somewhat ☐ Moderate ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderate ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderate ☐ 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 ☐ Moderate ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderate ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderate ☐ Quite a bit
5. Participating in social activities outside your home?	☐ Not at all ☐ Somewhat ☐ Moderate ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderate ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderate ☐ Quite a bit
6. Emotional health (nervousness, depression, etc)?	☐ Not at all ☐ Somewhat ☐ Moderate ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderate ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderate ☐ Quite a bit
7. Feeling frustrated?	☐ Not at all ☐ Somewhat ☐ Moderate ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderate ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderate ☐ Quite a bit