Boston Urogynecology Associates
New Patient Form
Please fill out completely before your visit

Name_____ Date_____
Who referred you to see us?_____
Who is your primary care doctor?_____
Who is your gynecologist?_____
What is the reason for your visit today?_____

Pregnancy history

Number of pregnancies_____ Number of vaginal deliveries_____
Number of living children_____ Forceps deliveries? Yes ☐ No ☐
Weight of largest baby _____ Number of c-sections_____

Medical history (check all that apply)

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

Surgical history

☐ Bladder surgery
☐ Prolapse surgery
☐ Hernia surgery
☐ Hysterectomy (abdominal or vaginal?)
☐ Ovaries removed?

Other medical problems:

_____
_____
_____
_____
_____

Other surgeries:

_____
_____
_____
_____
_____

Medications ☐ None
(*Use separate sheet if needed*)

_____
_____
_____
_____

Drug allergies ☐ None

_____
_____
_____
_____
_____

Social History ☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widow

Do you work? Y N What do you do?_____
Exercise? Y N How often?_____
Sexually active? Y N How often?_____
Do you smoke? Y N How many packs per day?_____
Alcohol Y N Type of alcohol_____ How often_____
Caffeine Y N Type _____ How often_____
Recreational drugs Y N Type_____ How often_____
Do you feel safe in your relationships? _____

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

	Relationship		Relationship
High cholesterol		Prolapse surgery	
Heart disease		Diabetes	
High blood pressure		Gyn cancer	
Bladder surgery		Other cancer	

Review of Systems: *Do you have any of these problems now?*

General
☐ Feeling tired
☐ Fever
☐ Significant weight loss/gain

Skin
☐ Abnormal mole
☐ Rash

Eyes
☐ Irritation
☐ Vision changes

Ears/nose/mouth
☐ Hearing loss
☐ Ear pain
☐ Sore throat
☐ Snoring
☐ Dry mouth
☐ Mouth ulcers

Lungs
☐ Shortness of breath
☐ Cough frequently
☐ Cough up mucus or blood
☐ Wheezing

Breast
☐ Breast lumps
☐ Breast tenderness
☐ Nipple discharge

Heart
☐ Chest pain
☐ Palpitations
☐ Short of breath while lying down

Gastrointestinal
☐ Heartburn
☐ Pain with swallowing
☐ Nausea or vomiting
☐ Abdominal pain
☐ Diarrhea
☐Constipation
☐ Rectal bleeding

Endocrine
☐ Hot flashes
☐ Night sweats
☐ Vaginal dryness
☐ Decreased sex drive
☐ Problems having orgasm

Musculoskeletal
☐ Muscle aches
☐ Muscle weakness
☐ Joint pain
☐ Back pain

Neurologic
☐ Frequent headaches
☐ Dizziness
☐ Pass out
☐ Weakness
☐ Numbness

Psychiatric
☐ Depression
☐ Alcoholism
☐ Insomnia

Genitourinary system

Do you urinate very frequently? ☐Yes ☐No
Do you have to rush to get to the bathroom? ☐Yes ☐No ☐Sometimes
Do you have pain or burning when you urinate? ☐Yes ☐No ☐Sometimes
Is your urine ever bloody? ☐Yes ☐No ☐Sometimes
Do you accidentally lose urine with any of the following activities?
☐ laughing ☐ sneezing ☐ exercising ☐ getting out of bed
☐ coughing ☐ lifting ☐ standing up
Do you lose urine during sex? ☐Yes ☐No ☐Not applicable
Do you get up from sleeping to go to the bathroom? ☐Yes How many times?_____ ☐No
Do you ever lose urine while sleeping? ☐Yes ☐No
Do you ever leak urine after a strong urge? ☐Yes ☐No ☐Sometimes
Do you wear pads for your leakage? ☐Yes ☐No
If yes, what type? ☐ pantyliner or tissue ☐ pad ☐ adult diaper
How many pads per day?_____
Do you dribble urine after going to the bathroom? ☐Yes ☐No ☐Sometimes
Do you ever have trouble emptying your bladder? ☐Yes ☐No ☐Sometimes
Do you ever push to empty your bladder completely? ☐Yes ☐No ☐Sometimes
Is your urine stream: ☐continuous ☐stop and start
Is your urine stream: ☐strong ☐weak ☐variable
Do you feel your pelvic organs falling out? ☐Yes ☐No ☐Sometimes
Do you feel anything bulging out of the vagina? ☐Yes ☐No ☐Sometimes
Do you feel heaviness or pressure in the vagina? ☐Yes ☐No ☐Sometimes
Are your bowel movements: ☐Normal ☐Constipated ☐Diarrhea ☐Variable
Do you ever leak or lose stool? ☐Never ☐Rarely ☐Monthly ☐Every day

BOSTON UROGYNECOLOGY ASSOCIATES

725 Concord Avenue, Suite 3300, Cambridge, MA 02138
617-354-5452 Fax 617-497-7503

Anthony DiSciullo, M.D. Eman Elkadry, M.D. Lekha Hota, M.D. Peter Rosenblatt, M.D.
Katherine Hanaway, M.D. Leah Moynihan, NP Kate Nolan, NP

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: ( ) _____

Cellular or Pager Number: ( ) _____ Email:_____

Employer:_____

Emergency Contact:_____ Phone: ( ) _____

Relationship:_____

Insurance Information

Subscriber:_____

ID#:_____ 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:_____

☐ Other Physician

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone:_____

Boston Urogynecology Associates
Pelvic Floor Questionnaire (PFDI)

Instructions:
Please answer the following questions by placing an "**X**" in the appropriate box. If you are unsure about how to answer a question, give the best answer you can. While answering these questions, please consider your symptoms during the past **three months.** Thank you for your help.

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

		No	Yes		Not at all	Somewhat	Moderately	Quite a Bit
1.	Do you usually experience *pressure* in the lower abdomen?			If yes, how much does this bother you?	1	2	3	4
2.	Do you usually experience *heaviness or dullness* in the pelvic area?			If yes, how much does this bother you?				
3.	Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?			If yes, how much does this bother you?				
4.	Do you usually have to push on the vagina or around the rectum to have or complete bowel movement?			If yes, how much does this bother you?				
5.	Do you usually experience a feeling of incomplete bladder emptying?			If yes, how much does this bother you?				
6.	Do you every have to push up on a bulge in the vaginal area with your fingers to start or complete urination?			If yes, how much does this bother you?				
7.	Do you feel you need to strain too hard to have a bowel movement?			If other than never, how much does this bother you?				
8.	Do you feel you have not completely emptied your bowels at the end of a bowel movement?			If other than never, how much does this bother you?				
9.	Do you usually lose stool beyond your control if your stool is well formed?			If yes, how much does this bother you?				
10.	Do you usually lose stool beyond your control if your stool is loose or liquid?			If yes, how much does this bother you?				
11.	Do you usually lose gas from the rectum beyond your control?			If yes, how much does this bother you?				
12.	Do you usually have pain with you pass stool?			If yes, how much does this bother you?				
13.	Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?			If yes, how much does this bother you?				
14.	Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?			If yes, how much does this bother you?				
15.	Do you usually experience frequent urination?			If yes, how much does this bother you?				
16.	Do you usually experience urine leakage associated with a feeling of urgency that is a strong sensation of needing to go to the bathroom?			If yes, how much does this bother you?				

		No	Yes		Not at all	Somewhat	Moderately	Quite a Bit
17.	Do you usually experience urine leakage related to coughing, sneezing, or laughing?			If yes, how much does this bother you?				
18.	Do you usually experience small amounts of urine leakage (that is, drops)?			If yes, how much does this bother you?				
19.	Do you usually experience difficulty in emptying your bladder?			If yes, how much does this bother you?				
20.	Do you usually experience *pain* or *discomfort* in the lower abdomen or genital region?			If yes, how much does this bother you?				

Boston Urogynecology Associates
Female Pelvic Medicine & Reconstructive Surgery

PELVIC FLOOR QUESTIONNAIRE (PFIQ)

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

Instructions:
Some women find that bladder, bowel or vaginal symptoms affect their activities, relationships and feelings. For each question, place and "**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 **during the past three months.**

How do symptoms or conditions related to the following usually affect you?

1. Ability to do household chores (cooking, housecleaning, laundry)?

	Not at all	Somewhat	Moderately	Quite a Bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

2. Ability to do physical activities such as walking, swimming, or other exercise?

	Not at all	Somewhat	Moderately	Quite a Bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

3. Entertainment activities such as going to a movie or concert?

	Not at all	Somewhat	Moderately	Quite a Bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

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
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

Boston Urogynecology Associates
Female Pelvic Medicine & Reconstructive Surgery

PELVIC FLOOR QUESTIONNAIRE (PFIQ) – (page 2)

5. Participating in social activities outside your home?

	Not at all	Somewhat	Moderately	Quite a Bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

6. Emotional health (nervousness, depression, etc.)?

	Not at all	Somewhat	Moderately	Quite a Bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

7. Feeling frustrated?

	Not at all	Somewhat	Moderately	Quite a Bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

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

Instructions: 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 the doctors understand what is important to patients about their sex lives. Please check the box that best answers the question for you. While answering the question, 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 activity 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 affect 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. Compare 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

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 last 3 months**. You may or may not have symptoms in each of these three areas, but please be sure to mark an answer in **all 3 columns** for each question. If do not have symptoms in one of these areas, then the appropriate answer would be "Not at all" in the corresponding column for each question.

EXAMPLE

For the following question:

If your bladder symptoms interfere with your ability to drive a car *moderately*, and your bowel symptoms interfere with your ability to drive a car *somewhat*, but your vaginal or pelvic symptoms do not interfere with your ability to drive a car or you have no vaginal or pelvic symptoms then you should place an X in the corresponding boxes as indicated below:

How do symptoms or conditions related to the following usually affect your ↓ →→→→	***Bladder or urine***	***Bowel or rectum***	***Vagina or Pelvis***
1. ability to drive a car	☐ Not at all ☐ Somewhat ☒ Moderately ☐ Quite a bit	☐ Not at all ☒ Somewhat ☐ Moderately ☐ Quite a bit	☒ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

Please make sure to answer all 3 columns for each and every question.
Thank you for your cooperation

Pelvic Floor Impact Questionnaire – short form 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 last 3 months**. Please be sure to mark an answer in **all 3 columns** for each question. Thank you for your cooperation.

How do symptoms or conditions related 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 ☐ 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