Advanced Urogynecology of Michigan P.C.
22731 Newman St., Suite 200, Dearborn, MI 48124
Office (313) 982-0200 | Fax (313) 982-0500 | www.augm.org

Dear ___________________________,

We have scheduled an appointment for you on:
___________________________________ at _________ a.m. / p.m.

Before your first appointment, please make sure you have done the following.

1. Enclosed you will find the patient information packet which you **must fill out completely** and bring with you to the appointment. If you do not bring it or it is not completely filled out, your appointment may be delayed.

2. Things to bring with you to your appointment:
   - Insurance cards with picture I.D.
   - Name, address and phone number of your physician who we may send a consultation letter to (example: primary physician, OB/GYN).
   - A current list of medications that you are taking including birth control.
   - A list of any allergies.
   - Insurance referral from your **PCP** if needed.

3. **Please arrive 30 min. early for your appointment.**

NOTE: YOU ARE RESPONSIBLE TO KNOW YOUR INSURANCE COVERAGE!

If you do not have office visit coverage, or if you have a co-pay, coinsurance and / or deductible, this will be collected at time of service unless prior arrangements have been made.

If you cannot keep your appointment, please notify us as soon as possible so that we can accommodate someone else in your appointment slot. Please note that appointment cancellation will delay the availability of your next appointment and may result in a delay in your healthcare.

No show or calls less than 24 hours may be subject to an administrative fee of $25.00 per our office policies and procedures.

We shall attempt to remind you a few days prior to your visit, however, it is your responsibility to remember the date and time of your appointment.

ADVANCED UROGYNECOLOGY OF MICHIGAN, PC

TODAY'S DATE: ______________

PATIENT INFORMATION SHEET						
Patient's Name					Home Phone	
Street Address					Cell Phone	
City		State	Zip		Email	
Age	Date of Birth		Marital Status: Single ___ Married ___ Widowed___ Divorced ___ Separated ___			Race
Occupation:						
Pharmacy Name			Pharmacy Phone		Pharmacy Address	
Secondary Pharmacy			Pharmacy Phone		Pharmacy Address	

INSURANCE INFORMATION					
Primary Insurance Carrier			Secondary Insurance Carrier		
Subscriber Name			Subscriber Name		
Relationship to patient:	Social Security No.	Date of Birth	Relationship to patient:	Social Security No.	Date of Birth
Employer	Business Phone		Employer	Business Phone	
Contract #			Contract #		
Group #	Service Code		Group #	Service Code	

PARENT'S INFORMATION (ONLY if patient is under 18 or insurance is in parent's name)			
FATHER OR GUARDIAN		MOTHER OR GUARDIAN	
Name		Name	
Employer		Employer	
Employer Address		Employer Address	
Business Phone	Date of Birth	Business Phone	Date of Birth
Home Phone	Social Security No.	Home Phone	Social Security No.

EMERGENCY CONTACT		
Name:	Phone #	Relationship:

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CANCELLATION AND NO-SHOW APPOINTMENT POLICY

We at Advanced Urogynecology of Michigan (AUGM) understand that sometimes you need to cancel or reschedule your appointment due to emergencies. If you are unable to keep your appointment, please notify us as soon as possible.

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

If you cannot keep your appointment, please notify us as soon as possible so that we can accommodate someone else in your appointment slot. Please note that appointment cancellation will delay the availability of your next appointment, and may result in a delay in your healthcare.

No-Show or Cancellations with less than 24 hours' notice may be subject to an administrative fee not to exceed $75.00 per our office policies and procedures.

**** Please note that if you are more than 15 minutes PAST your scheduled time, your visit may be cancelled. This is so that we do not inconvenience the other patients who show up on time. Moreover, this will also be considered as a last minute cancellation and you may be charged a cancellation/late fee.**

We take pride in seeing our patients in a timely manner and do not like to keep them waiting. I am sure you understand this and will help us ensure that your visit is timely, efficient and satisfactory.

I understand AUGM's appointment cancellation and no-show policy and understand my responsibility to plan appointments accordingly and notify AUGM appropriately if I have difficulty fulfilling my scheduled appointments.

______________________________	____________________
Patient's Name	Date of Birth
______________________________	____________________
Signature of Patient or Guardian	Date

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PAYMENT POLICY

Thank you for choosing us as your healthcare provider. We are committed to providing you with top quality healthcare.

We have developed this payment policy because some of our patients have had questions regarding patient and insurance responsibility for services rendered. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

- We participate in most insurance plans, including Medicare. If you are not insured by a plan we are contracted with, you are responsible for services not covered by your plan.

- If you are insured by a plan we are contracted with, but don't have an up to date insurance card and we are unable to verify your coverage and benefits, payment in full is required at time of service.

- Knowing your insurance benefits is your responsibility. Please contact your insurance company with any question you may have regarding your coverage if we are not able to answer them.

- All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payment and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

- Please be aware that some of the services you receive may not be covered by your insurance. You are required to pay for these services at the time of visit.

- During your visit, there may be certain key tests done such as a urinalysis (checking your urine for infection/microscopic blood), assessment of post void residual to see how well you are emptying your bladder, or a vaginal smear. Your symptoms may also require us to send the urine to the lab for cytology (cell screen), culture to look for an infection etc…You will be responsible for paying the bill if the services are not covered by your insurance. Please understand that these tests are necessary for your health management.
- We will submit our claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

- If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

- If your account is over 30 days past due, you will be charged a late fee. If your account is 90 days past due, you will have 20 days to pay your account in full. Partial payments will not be accepted unless prior arrangements are made or otherwise negotiated. Please be aware that if a balance on your account remains unpaid, we may refer your account to a collection agency.

- Our office policy is to charge for missed appointments not canceled within 24 hours of a scheduled appointment. Please help us to serve you better by keeping your regularly scheduled appointment.

- We accept VISA, MASTERCARD, CHECK, MONEY ORDERS and **CARE CREDIT**. There is a $25.00 fee for returned checks.

At AUGM we are committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

______________________________________ ______________________

Signature of patient or responsible party **Date**

____

Name of patient or responsible party

ADVANCED UROGYNECOLOGY OF MICHIGAN, PC

TODAY'S DATE: ________________

Name:	Age:	Birthday:	Occupation:

Primary Physician:	**How Were You Referred To Our Office:** ___ Family ___ Friend ___Patient ___ Insurance ___ Health Fair ___ Other ______________________ ___ Physician ______________________________ Address ______________________________
Physician Address:	
Phone Number:	

The Reason for Today's Visit is:

Is the problem you are here for today causing you pain? ___ Yes ___ No

Gynecologic History

Age when menses started: _____ Last menstrual period: ______ How many days does it last? ______

Period occurs every: < 21 days ____ 21-30 days ____ 30-35 days ____ > 35 days ____

Do you have menstrual cramps/pain? _______ How severe? Mild ___ Moderate ____ Severe ____

Do you ever bleed between periods? ________ After intercourse? ________

What do you use for contraception? ________________________

Have you ever had:

_____ fibroids	_____ ovarian cysts	_____ vaginal dryness/itching
_____ endometriosis	_____ pelvic inflammatory disease	_____ hot flashes
_____ genital herpes	_____ genital warts	_____ yeast infection
_____ gonorrhea	_____ syphilis	_____ bacterial vaginosis
_____ chlamydia	_____ mood swings	

Have you gone through menopause? Yes No At what age? ______

Date of last pap smear? _____________ Normal Yes No

Have you ever had an abnormal pap smear? Yes No Did you have: cyro colpo leep

Date of last mammogram: ___________ Normal? Yes No Self breast exam? Yes No

Sexual History

Are you sexually active? Yes No Do you ever have pain with intercourse? Yes No

Is your sex life satisfactory? Yes No Sexual Preference: Male Female Both

Social History (*Do you*):

Smoke? Yes No If yes, how much: ________Day How long have you smoked? _________

Have you ever smoked? Yes No If yes, how much: _________Day When did you quit? ________

Drink Alcohol? Yes No How much per week? __________ Seat Belt? Yes No

Drink beverage with caffeine? Yes No How much per day? ___________

Use street drugs? Yes No Do you exercise? Yes No Describe__________________________

Have you suffered from physical, emotional, sexual abuse? ______________________________

How do you learn new things – reading, videos, demonstrations? __________________________

Urinary Problems (*Do you have*):

_____Urine loss with cough
_____Urine loss with urgency
_____Urinary urgency
_____Urinary frequency
____ Pain with urination
____ Blood in urine
____ Bladder infections
____ Difficulty urinating
_____ Bed Wetting
_____ To get up at night to urinate
_____ To wear incontinence products
_____ Uncontrollable loss of stool

Obstetrical History How many times have you been pregnant? ________

Weight of Baby	Type of Delivery	Weight of Baby	Type of Delivery

Do you have to take antibiotics before going to the dentist or having a procedure? Yes No

Have you been vaccinated for Pneumonia? Yes No Influenza? Yes No

Medical History

___ Diabetes
___ High Blood Pressure
___ Stroke
___ Arthritis
___ Glaucoma
___ Tuberculosis
___ Asthma
___ Cardiac problems (heart attack, etc.)
___ Anemia
___ Bleeding problems
___ Liver Disease
___ Osteoporosis
___ Gall Bladder Disease
___ Psychiatric problems
___ Cancer
___ Multiple Sclerosis
___ Parkinson's
___ Alzheimer's
___ Fibromyalgia
___ HIV/AIDS
___ Thyroid

Do you have difficulty: Reading ___ Hearing ___ Seeing ____

Surgical History (If needed, please continue on the medications form) **ASA: 1 2 3 4**

Year	Operation	Hospital

Family History M (mother) F (father) S (sister) B (brother) O (other)

___ Breast Cancer
___ Heart Disease
___ Seizure disorders
___ High Blood Pressure
___ Alcoholism
___ Colon Cancer
____ Alzheimer's
____ Uterine cancer
____ Parkinson's
____ Ovarian Cancer
____ Stroke
____ Psychiatric disorders

Have you recently had or experienced:

___ Constipation
___ Heart attack
___ Swollen glands
___ Vomiting blood
___ Change in vision
___ Change in hearing
___ Chest Pain
___ Suicidal thoughts
___ Blood in stool
___ Headaches
___ Coughing up blood
___ Difficulty breathing
___ Weakness/ Numbness
___ Soiling pants
___ Abnormal hair growth
___ Hoarseness
___ Sudden weight change
___ Difficulty sleeping
___ Diarrhea
___ Skin problems
___ Breast lumps
___ Appetite change
___ Depression

______________________ ____________ ______________________ ____________
Patient's Signature Date Reviewer's Signature Date

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MEDICATIONS, ALLERGIES AND SURGERIES

Today's Date: ____________________

Name: ____ Date of Birth: ________________

Please provide us with a complete list of all medications, vitamins and herbal supplements you are currently taking. THIS IS VITAL FOR YOUR HEALTHCARE AND WILL HELP AVOID DANGEROUS INTERACTIONS. This will help us to provide the best care for our patients.

Prescribed			
Name of Medication (Brand or generic name)	**Dosage** (mg, mcg, units, etc.)	**Administered** (Oral, topical, injection, etc.)	**Frequency** (How often do you take it?)

Non-Prescribed or Over-the-counter Medication			
Name of Medication (Brand or generic name)	**Dosage** (mg, mcg, units, etc.)	**Administered** (Oral, topical, injection, etc.)	**Frequency** (How often do you take it?)

Name: ____ Date of Birth: ________________

PLEASE STATE YOUR ALLERGIES

Drug/Agent	What Happens?

PLEASE LIST ALL SURGERIES IN CHRONOLOGICAL ORDER

Year	Operation/Procedure	Hospital

ADVANCED UROGYNECOLOGY OF MICHIGAN, PC

MESA URINARY INCONTINENCE QUESTIONNAIRE (UIQ)

NAME:____ DATE:__________________

Please check (✓) the appropriate box.

1. Over the past 12 months, have you had urine loss beyond your control?
   ______Yes ______ No
2. How long ago did your urine loss start? ____Years ____Months ____Days
3. When does the urine loss usually occur?
   _______Daytime only _______Nighttime only _______Both day/ night time
4. How Often?____
5. Do you use anything for protection against leaked urine? _______Yes ______No

On **average,** how many of each of these do you use for protection? (Please write the number used and check each day or each week)

	Number Used	**EachDay/EachWeek**
Sanitary Napkins	_______	______/______
Pads like those placed on furniture (ex. Blue pads)	_______	______/______
Adult wetness control garments (ex. Attends, Depends)	_______	______/______
Toilet paper or facial tissues	_______	______/______
Something else (please list)	_______	______/______

6. While awake, when you are having urine loss problems, how much urine would you say you lose without control EACH TIME?
   ______ A few drops to less than ½ teaspoon
   ______ ½ teaspoon to less than 2 tablespoons
   ______ 2 tablespoons to ½ cup
   ______ ½ cup or more

7. When you lose urine, does it usually:
   _______ Just create some moisture
   _______Wet your underwear
   _______Trickle down your thigh
   _______ Wet the floor

8. Generally, how many times do you usually urinate from the time you wake up to the time before you go to bed?
   _______ Times

9. Generally, how many times do you usually urinate after you have gone to sleep at night?
   _______Times

MESA QUESTIONNAIRE

NAME: DATE:

	URGE SYMPTOMS	Never	Rarely	Sometimes	Often
1	Some women receive very little warning and suddenly find that they are losing, or are about to lose urine beyond their control. How often does this happen to you? (Would you say…)	0	1	2	3
2	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? (Would you say…)	0	1	2	3
3	Do you lose urine when you suddenly have the feeling that your bladder is full?	0	1	2	3
4	Does washing your hands cause you to lose urine?	0	1	2	3
5	Does cold weather cause you to lose urine?	0	1	2	3
6	Does drinking cold beverages cause you to lose urine?	0	1	2	3

(For Office Use Only)
Urge Score: ___________ Percentage: __________

	STRESS SYMPTOMS	Never	Rarely	Sometimes	Often
1	Does coughing gently cause you to lose urine?	0	1	2	3
2	Does coughing hard cause you to lose urine?	0	1	2	3
3	Does sneezing cause you to lose urine?	0	1	2	3
4	Does lifting things cause you to lose urine?	0	1	2	3
5	Does bending cause you to lose urine?	0	1	2	3
6	Does laughing cause you to lose urine?	0	1	2	3
7	Does walking briskly or jogging cause you to lose urine?	0	1	2	3
8	Does straining if you are constipated, cause you to lose urine?	0	1	2	3
9	Does getting up from a sitting to a standing position cause you to lose urine?	0	1	2	3

(For Office Use Only)
Stress Score: ___________ Percentage: ___________

ADVANCED UROGYNECOLOGY OF MICHIGAN, PC

NAME: ________________________________ DOB: _____________ DATE: _____________

Urogenital Distress Inventory - 6

Please read the first column of symptoms and circle "Yes" or "No" for each symptom. Then, for each question marked by a "Yes" answer, work across the page and tell us how bothersome that symptom is for you currently.

Do you currently experience...

If Yes, circle one response below that best describes how bothersome that symptom is for you.

	NO	YES	Not at all	Slightly	Moderately	Greatly
1. Frequent Urination?	NO	YES	0	1	2	3
2. Urine leakage related to the feeling of urgency?	NO	YES	0	1	2	3
3. Urine leakage related to physical activity, coughing, or sneezing?	NO	YES	0	1	2	3
4. Small amounts of urine leakage?	NO	YES	0	1	2	3
5. Difficulty emptying your bladder?	NO	YES	0	1	2	3
6. Pain in the lower abdominal or genital area?	NO	YES	0	1	2	3

PGI-S

1. Circle the one number that best describes how your urinary tract condition is now?

Normal	Mild	Moderate	Severe
1	2	3	4

ADVANCED UROGYNECOLOGY OF MICHIGAN, PC

Name: ________________________________ DOB: ____________ Date: ____________

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 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, 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

ADVANCED UROGYNECOLOGY OF MICHIGAN P.C.

The PELVIC PAIN and URGENCY/FREQUENCY Questionnaire

Name: ______________________________ DOB: _____________ Date: ____________

For each question below, please circle the answer that best describes how you feel. The last 2 columns on the right are for your doctor to assess your answers. Please do not mark anything in these columns.

		0	1	2	3	4	SYMPTOM SCORE	BOTHER SCORE
1	How many times do you go to the bathroom during the day?	3-6	7-10	11-14	15-19	20+		
2a	How many times do you go to the bathroom at night?	0	1	2	3	4+		
2b	If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe			
3	Are you currently sexually active? YES ______ NO ______							
4a	IF YOU ARE SEXUALLY ACTIVE, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always			
4b	If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
5	Do you have pain associated with your bladder or in you pelvis (vagina, lower abdomen, urethra, perineum, testes, or scrotum)?	Never	Occasionally	Usually	Always			
6	Do you still have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7a	If you have pain, is it usually …		Mild	Moderate	Severe			
7b	Does your pain bother you?	Never	Occasionally	Usually	Always			
8a	If you have urgency, is it usually …		Mild	Moderate	Severe			
8b	Does your urgency bother you?	Never	Occasionally	Usually	Always			
SYMPTOM SCORE (1, 2a, 4a, 5, 6, 7a, 8a) - SUBTOTAL								
BOTHER SCORE (2b, 4b, 7b, 8b) - SUBTOTAL								
TOTAL SCORE (Symptom Score + Bother Score) =								

ADVANCED UROGYNECOLOGY OF MICHIGAN P.C.

PELVIC ORGAN PROLAPSE / URINARY INCONTINENCE SEXUAL FUNCTION QUESTIONNAIRE (PISQ-12)

NAME: ____________________________________ DOB: ______________ DATE: ______________

Instructions: All information is **CONFIDENTIAL**. Only used to help physicians understand what is important to patients about their sex lives. Please consider your sexuality over the past six months and check the box that best answers the question for you.

1. How frequently do you feel sexual desire? (Wanting to have sex, planning to have sex, feeling frustrated due to lack of sex, etc.)

   ☐ Daily (0) ☐ Weekly (1) ☐ Monthly (2) ☐ Less than once a month (3) ☐ Never (4)

2. Do you climax (have an orgasm) when having sexual intercourse with your partner?

   ☐ Always (0) ☐ Usually (1) ☐ Sometimes (2) ☐ Seldom (3) ☐ Never (4)

3. Do you feel sexually excited (turned on) when having sexual activity with your partner?

   ☐ Always (0) ☐ Usually (1) ☐ Sometimes (2) ☐ Seldom (3) ☐ Never (4)

4. How satisfied are you with the variety of sexual activities in your current sex life?

   ☐ Always (0) ☐ Usually (1) ☐ Sometimes (2) ☐ Seldom (3) ☐ Never (4)

5. Do you feel pain during sexual intercourse?

   ☐ Always (4) ☐ Usually (3) ☐ Sometimes (2) ☐ Seldom (1) ☐ Never (0)

6. Are you incontinent of urine (leak urine) with sexual activity?

   ☐ Always (4) ☐ Usually (3) ☐ Sometimes (2) ☐ Seldom (1) ☐ Never (0)

7. Does fear of incontinence (either stool or urine) restrict your sexual activity?

   ☐ Always (4) ☐ Usually (3) ☐ Sometimes (2) ☐ Seldom (1) ☐ Never (0)

8. Do you avoid sexual intercourse because of bulging in the vagina (either bladder, rectum, or vagina falling out)?

   ☐ Always (4) ☐ Usually (3) ☐ Sometimes (2) ☐ Seldom (1) ☐ Never (0)

9. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?

   ☐ Always (4) ☐ Usually (3) ☐ Sometimes (2) ☐ Seldom (1) ☐ Never (0)

10. Does your partner have a problem with erections that affects your sexual activity?

    ☐ Always (4) ☐ Usually (3) ☐ Sometimes (2) ☐ Seldom (1) ☐ Never (0)

11. Does your partner have a problem with premature ejaculation that affects your sexual activity?

    ☐ Always (4) ☐ Usually (3) ☐ Sometimes (2) ☐ Seldom (1) ☐ Never (0)

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 (4) ☐ Less intense (3) ☐ Same intensity (2) ☐ More intense (1) ☐ Much more intense (0)

ADVANCED UROGYNECOLOGY OF MICHIGAN, PC

Name: ________________________________ DOB: ____________ Date: ___________

PELVIC FLOOR DISTRESS INVENTORY – Short form 20

1. Do you usually experience pressure in the lower abdomen? **No / Yes**

If **YES**, how much does this bother you?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

2. Do you usually experience heaviness or dullness in the pelvic area? **No / Yes**

If **YES**, how much does this bother you?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area? **No / Yes**

If **YES**, how much does this bother you?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement? **No / Yes**

If **YES**, how much does this bother you?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

5. Do you usually experience a feeling of incomplete bladder emptying? **No / Yes**

If **YES**, how much does this bother you?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

6. Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination? **No / Yes**

If **YES**, how much does this bother you?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

ADVANCED UROGYNECOLOGY OF MICHIGAN, PC

Name: ________________________________ DOB: _____________ Date: ____________

7. Do you feel you need to strain too hard to have a bowel movement? **No / Yes**

If **YES**, how much does this bother you?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

8. Do you feel you have not completely emptied your bowels at the end of a bowel movement? **No / Yes**

If **YES**, how much does this bother you?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

9. Do you usually lose stool beyond your control if stool is well formed? **No / Yes**

If **YES**, how much does this bother you?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

10. Do you usually lose stool beyond your control if stool is loose or liquid? **No / Yes**

If **YES**, how much does this bother you?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

11. Do you usually lose gas from the rectum beyond your control? **No / Yes**

If **YES**, how much does this bother you?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

12. Do you usually have pain when you pass your stool? **No / Yes**

If **YES**, how much does this bother you?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement? **No / Yes**

If **YES**, how much does this bother you?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

ADVANCED UROGYNECOLOGY OF MICHIGAN, PC

Name: ______________________________ DOB: ___________ Date: ___________

14. Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement? **No / Yes**

If **YES**, how much does this bother you?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

15. Do you usually experience frequent urination? **No / Yes**

If **YES,** how much does this bother you?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

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? **No / Yes**

If **YES**, how much does this bother you?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

17. Do you usually experience urine leakage related to coughing, sneezing, or laughing? **No / Yes**

If **YES**, how much does this bother you?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

18. Do you usually experience small amounts of urine leakage (that is, drops)? **No / Yes**

If **YES**, how much does this bother you?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

19. Do you usually experience difficulty emptying your bladder? **No / Yes**

If **YES**, how much does this bother you?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

20. Do you usually experience pain or discomfort in the lower abdomen or genital region? **No / Yes**

If **YES**, how much does this bother you?
☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

Notes and Questions for the Doctor