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

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

1. Below is the patient information packet which you **must fill out completely** and my chart to us or email to Urogyn@augm.org prior to your appointment. If you do not send it and have it completely filled out, your appointment may be delayed or cancelled.

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 at your scheduled time 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 a business day prior to your appointment may be subject to an administrative fee of $50.00 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.
PAPERWORK MUST BE COMPLETED PRIOR TO YOUR APPOINTMENT

ADVANCED UROGYNECOLOGY OF MICHIGAN, PC

TODAY'S DATE: _____

Name:	Age:	Birthday:	Occupation:
Primary Physician:	**How Were You Referred To Our Office:** ☐ Family ☐ Friend ☐ Online ☐ Insurance ☐ Other _____		
Physician Address:	☐ Physician _____		
Phone Number:	Address _____		

Pharmacy: _____ City:_____ Cross roads:_____

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? Yes After intercourse?

What do you use for contraception? _____

Have you ever had (Y or N):

_____ 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? I don't know At what age? _____

Date of last pap smear? _____ Normal No

Have you ever had an abnormal pap smear? No Did you have: not sure

Date of last mammogram: _____ Normal? N/A Self breast exam? Yes

No

Sexual History

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

No Is your sex life satisfactory? No Sexual Preference: Both

Social History (*Do you*):

Do you Smoke? No If yes, how much: _____Day How long have you smoked?

Have you ever smoked? No If yes, how much: _____Day When did you quit?

Drink Alcohol? No How much per week? _____ Seat Belt? No

Drink beverage with caffeine? No How much per day? _____

Use street drugs? No Do you exercise? 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? _____

Have you been vaccinated for Pneumonia? _____ Influenza? _____

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 ☐ **ASA:** 4

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

Breast Cancer	High Blood Pressure	Alzheimer's	Ovarian Cancer
Heart Disease	Alcoholism	Uterine Cancer	Stroke
Seizure Disorders	Colon Cancer	Parkinson's	Psychiatric Disorders

Have you recently had or experienced (Y or N):

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

_____ _____ _____ _____

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 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?)

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?)

ADVANCED UROGYNECOLOGY OF MICHIGAN, PC

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? No
2. How long ago did your urine loss start? Years Months Days
3. When does the urine loss usually occur? Both day/night time
4. How Often?
5. Do you use anything for protection against leaked urine?

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.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

ADVANCED UROGYNECOLOGY OF MICHIGAN, PC

MESA QUESTIONNAIRE

NAME: _____ **DATE:** _____

	URGE SYMPTOMS	Never (0)	Rarely(1)	Sometimes(2)	Often(3)
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…)	○	○	○	○
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…)	○	○	○	○
3	Do you lose urine when you suddenly have the feeling that your bladder is full?	○	○	○	○
4	Does washing your hands cause you to lose urine?	○	○	○	○
5	Does cold weather cause you to lose urine?	○	○	○	○
6	Does drinking cold beverages cause you to lose urine?	○	○	○	○

(For Office Use Only)

Urge Score: _____ Percentage: _____

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

(For Office Use Only)

Stress Score: _____ Percentage: _____

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+	20+ (4)	
2a	How many times do you go to the bathroom at night?	0	1	2	3	4+	1 (1)	
2b	If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe			Severe (
3	Are you currently sexually active?	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		Always (3)	
4b	If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always			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		Always (3)	
6	Do you still have urgency after going to the bathroom?	Never	Occasionally	Usually	Always		Always (3)	
7a	If you have pain, is it usually …		Mild	Moderate	Severe		N/A	
7b	Does your pain bother you?	Never	Occasionally	Usually	Always			Always (
8a	If you have urgency, is it usually …		Mild	Moderate	Severe		N/A	
8b	Does your urgency bother you?	Never	Occasionally	Usually	Always			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: _____

Lead-In Questions

1. Which of the following best describes you?

- ☐ Not sexually active at all (**complete section 2 below**)
- ☐ Sexually active, with or without a partner (**skip to back PISQ-12 questions**)

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2. The following list includes reasons why you might not be sexually active. For each one please indicate how strongly you agree or disagree with it as a reason that you are not sexually active. (Responses: Strongly agree, Somewhat agree, Somewhat disagree, Strongly disagree).

A. No partner	☐ Strongly Agree	☐ Somewhat Agree	☐ Somewhat Disagree	☐ Strongly Disagree
B. No interest	☐ Strongly Agree	☐ Somewhat Agree	☐ Somewhat Disagree	☐ Strongly Disagree
C. Due to bladder or bowel problems (urinary or fecal incontinence) or due to a prolapse (a feeling or a bulge in the vaginal area)	☐ Strongly Agree	☐ Somewhat Agree	☐ Somewhat Disagree	☐ Strongly Disagree
D. Because of my other health problems	☐ Strongly Agree	☐ Somewhat Agree	☐ Somewhat Disagree	☐ Strongly Disagree
E. Pain	☐ Strongly Agree	☐ Somewhat Agree	☐ Somewhat Disagree	☐ Strongly Disagree

If you are not sexually active, you are done with this questionnaire. You do not have to complete the PISQ-12 questions

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

NAME: _____ DOB: _____ DATE: _____

Instructions: All information is **CONFIDENTIAL**. Following are a list of questions about you and your partner's sex life. Your answers will be 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? This feeling may include 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 the 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

PELVIC FLOOR DISTRESS INVENTORY – Short form 20

NAME: _____ DOB: _____ DATE: _____

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

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

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

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

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

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

If **YES**, how much does this bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

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

If **YES**, how much does this bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

ADVANCED UROGYNECOLOGY OF MICHIGAN, PC

PELVIC FLOOR DISTRESS INVENTORY – Short form 20

NAME: _____ DOB: _____ DATE: _____

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

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

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

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

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

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

If **YES**, how much does this bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

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

If **YES**, how much does this bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

ADVANCED UROGYNECOLOGY OF MICHIGAN, PC

PELVIC FLOOR DISTRESS INVENTORY – Short form 20

NAME: _____ DOB: _____ DATE: _____

15. Do you usually experience frequent urination? No

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

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?

If **YES**, how much does this bother you? No

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

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

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

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

If **YES**, how much does this bother you?

☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

Center of Excellence for the Management of Female Pelvic Floor Disorders
Advanced Urogynecology of Michigan P.C.
Salil Khandwala, MD FACOG FPMRS

"Pursuit of Excellence through Evidence-based medicine"

What goals do you want to achieve during your visit with us?

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____

Additional information:

_____
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