ChristianaCare

Center for Urogynecology and Pelvic Surgery
4735 Ogletown-Stanton Road, MAP II, Suite 1208
Newark, DE 19713
Phone: (302)623-4055 Fax: (302)623-4056

Dear _____:

Welcome to the Christiana Care Center for Uro-Gynecology and Pelvic Surgery!

Your appointment with _____ is scheduled on _____ at _____AM/PM at the following location:

Medical Arts Pavilion (MAP) II,	Smyrna Health & Wellness Center	Christiana Care Concord Center
Suite 1208	100 S. Main Street	161 Wilmington-West Chester Pike
4735 Ogletown-Stanton Road	Building C; Suite 215	Chadds Ford, PA 19317
Newark, DE 19713	Smyrna, DE 19977	

Enclosed in this packet is a medical history form as well as a current medication list for you to complete. Please list all of your medication (s) with the strength and amount you take and also how often you take them.

Also, you will find a bladder diary and also a pelvic floor questionnaire. These allow us to better understand our pelvic floor complaints. Instructions on how to complete these are found on the forms themselves.

If you have any questions regarding these papers, feel free to contact our office at the phone number listed above.

For those patients that have an HMO insurance plan: You are responsible for obtaining any referral you may need from your referring physician, PCP (primary/family doctor) and/ or your insurance company.

Please obtain your referral (if needed) prior to your appointment day and have a copy with you when you arrive to your appointment or have your doctor's office fax a copy to us prior to your appointment day.

*If you are unsure as to whether or not a referral is needed, please call your insurance company for clarification.

If your insurance requires you to pay a copay, please come prepared to pay the copay at the time of visit. We accept cash, check and all major credit cards (except American Express).

We look forward to meeting you!

Sincerely,

Babak Vakili, MD
Howard Goldstein, DO
Emily Saks, MD
Matthew Fagan, MD
Leia Collins, PA-C
Colleen Deturk, WNHP
Helen Cohen, WHNP
Amanda Wardwell, WHNP

Center for Urogynecology and Pelvic Surgery

Patient Registration

Patient Name: (Last) _____ (First)_____ (Middle)_____

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Birth Date: _____ Phone: _____ Work: _____ Cell: _____

Contact By: Home Cell Work Email Address: _____ Sex: ☐ Male ☐ Female

Marital Status: Single Married Divorced Widowed Separated Partner Other SSN: _____-_____-_____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐Asian and Black or African American ☐Asian and White ☐ Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White or Caucasian ☐Undetermined

Ethnicity: ☐Hispanic or Latino ☐ Non-Hispanic or Latino ☐Other or Undetermined Preferred Language: _____

Employment Status: (mark all that apply) ☐Full-time ☐Part-time ☐Self-Employed ☐Retired
☐Student ☐ Child ☐ Unemployed ☐Other: _____

Primary Care Provider: _____ Phone: _____
Preferred Pharmacy: _____ Phone: _____
Emergency Contact: _____ Phone: _____

Responsible Party (Party responsible for payment): Self Spouse Parent Other_____
Name: (Last) _____ (First) _____ Birth Date: _____
SSN: _____ Sex: Male Female
Address: _____
City: _____ State: _____ Zip: _____ Country: _____
Phone: _____ Work: _____ Fax: _____ Email: _____

Primary Insurance: _____ Effective Date: _____
Insured Party : Self Spouse Parent Other ID#: _____ Group #: _____
Subscriber Name: (Last) _____ (First)_____ Birth Date: _____

Secondary Insurance: _____ Effective Date: _____
Insured Party : Self Spouse Parent Other ID#: _____ Group #: _____
Subscriber Name: (Last)_____ (First)_____ Birth Date: _____

I authorize Christiana Care Health Service to release medical information to m insurance company, its intermediaries or carrier, or another physician's office. I hereby authorie direct payment of medical and/ or surgical benefits, to include medical benefits to which I am entitled from medicare, private insurance, and any other health plan to Christiana Care Health Services. I also permit copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing; I understand that, as these services were performed for me or my legal dependent, I am financially responsible for all charges whether or not paid by insurance.

X_____ X_____ ___/____/_____ _____

Signature of Patient or Legal Representative | Relationship of Patient, If Legal Representative | Date | Time:

Interpretation: The information presented orally to the ☐ patient ☐representative ☐decision maker was interpreted into (language) _____. The person for whom the information was interpreted stated s/he understood the interpretation.

X_____ X_____ ___/____/_____ _____

Interpreter Name/ Agency ID# | Staff Signature/ Title | Date | Time:

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New Patient Form

Name:_____ Date of Birth (MM/DD/YY): ____/____/____ Gender: _____

Provider referring you for this visit (if applicable): _____ Primary Care Provider: _____

Date of last gynecological visit: _____ Location/Provider: _____

Reason for Visit: _____ _____	Anything else you wish to discuss today: _____ _____ _____
Do you have an advanced directive (living will)? ☐Yes ☐No	Are you experiencing pain? ☐Yes ☐No *If yes, rate on a scale of 0-10 (0 being no pain, 10 being the worst)* Pain at rest: ____/10 Pain with activity: ____/10

Does the patient have a home care giver? ☐Yes ☐No ☐Declined ☐Unable to Verify ☐N/A ☐Other: _____

Home Caregiver Name/Relationship: _____ Home Caregiver Preferred Phone Number: (____)-____-____

LEARNING METHODS:

Do you have any Learning Barriers/Factors Affecting Learning?

☐ None at this time	☐ Cultural barrier	☐ Emotional state	☐ Language barrier	☐ Vision
☐ Acuity of illness	☐ Desire/Motivation	☐ Financial concerns	☐ Literacy	☐ Other _____
☐ Cognitive deficits	☐ Difficulty concentrating	☐ Hearing deficit	☐ Memory problems	_____

GYN MENSTRUAL STATUS:

Menstrual Status

Date of last menstrual period: _____ ☐ Postmenopausal ☐ Hysterectomy

Are you currently on hormone therapy? (Please circle) Yes No

Pregnancy Prevention/Contraception: ☐ N/A

☐ Condom	☐ Pills	☐ Other _____
☐ Depo Shot	☐ Rhythm or Withdrawal	☐ Ring
☐ IUD (Intrauterine Device)	☐ Spermacide	☐ Patch
☐ Implant/Nexplanon	☐ Sterilization:	
	☐ Tubal ligation	
	☐ Tubal occlusion	
	☐ Hysterectomy	
	☐ Partner vasectomy	

If you are menopausal, please complete section below (please circle where appropriate):

Age/year periods stopped: _____

Hysterectomy? Yes No

Hormone therapy? Yes, currently taking Yes, taken in the past Never taken

Hot Flashes? Yes No

Vaginal Dryness? Yes No

Postmenopausal bleeding? Yes No

Mood Symptoms? Yes No

Insomnia? Yes No

Bowel Issues? Yes No

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New Patient Form

ALLERGIES: *List all drug, environment and food allergies below* ☐ No known allergies

Substance	Type of Reaction

MEDICATIONS: *List all current medications and how they are taken. INCLUDE **VITAMINS** and **OVER THE COUNTER MEDICATIONS***

☐ No Current Medications

Medication Name	Dose	How often do you take it?	Medication Name	Dose	How often do you take it?

PREFERRED PHARMACIES	Name	Location	Phone Number
Local Pharmacy			
Mail Order Pharmacy			

SOCIAL HISTORY:

Alcohol Use: ☐ Current ☐ Past ☐ Never

What Type: ☐ Beer ☐ Wine ☐ Liquor ☐ Other: _____

Frequency: ☐ 1-2 times per year ☐ 1-2 times per month ☐ 1-2 times per week ☐ 3-5 times per week ☐ Daily

☐ Several times per day ☐ Other: _____

Tobacco Use: ☐ Smoker, current status unknown ☐ Never (less than 100 lifetime)

Frequency/PPD?: ☐ 4 or less cigarettes *(less than ¼ pack)*/day in last 30 days ☐ 5-9 cigarettes (¼ - ½ pack)/day in last 30 days ☐ 10 or more cigarettes (½ pack or more)/day in last 30 days

☐ Cigars or pipes daily within last 30 days ☐ Cigars or pipes but not daily within last 30 days ☐ Former smoker, quit more than 30 days ago

Tobacco Type: ☐ Cigarettes ☐ Cigars ☐ Oral/Chewed ☐ Pipe ☐ Vape ☐ Other: _____

Tobacco use per day:	Number of years:	Age started:	Age stopped:	Smoker in Household: ☐Yes ☐No

Substance Abuse: ☐ Current ☐ Past ☐ Never

If current or past, what type?: _____

Have you ever used street drugs with a needle? ☐ Yes ☐ No

Frequency: ☐ 1-2 times per year ☐ 1-2 times per month ☐ 1-2 times per week ☐ 3-5 times per week ☐ Daily

☐ Several times per day ☐ Other_____

Type:

Amphetamines	Hallucinogens/LSD	Marijuana	Other
Cocaine	Heroin	Methamphetamine	
Ecstasy	Inhalants/Glues/Solvents	Prescription Medications	

EXERCISE:

Level: ☐ None ☐ Occasional ☐ Moderate ☐ Vigorous ☐ Other

Type: ☐ Walking ☐ Aerobics ☐ Running ☐ Swimming ☐ Weightlifting ☐ Yoga ☐ Other: _____

Times per week: ☐ 1-2 times/week ☐ 3-4 times/week ☐ 5-6 times/week ☐ daily ☐ Other

FAMILY HISTORY: ☐Unknown ☐Adopted

Mark all that apply

	Father	*Mother*	*Brother*	*Sister*	*Maternal Grandfather*	*Maternal Grandmother*	*Paternal Grandfather*	*Paternal Grandmother*	*Other*
Cancer - Breast									
Cancer- Bladder									
Cancer- Kidney									
Cancer-Ovarian									
Cancer - Colon									
Deep vein thrombosis –blood clot									
Pulmonary embolism (blood clot in lung)									
Stroke									

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New Patient Form

MEDICAL HISTORY

☐ No known problems OR ☐ Check all that apply

Cardiovascular
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Heart disease/heart attack
- ☐ Heart Failure
- ☐ Atrial Fibrillation
- ☐ Stroke

Endocrine
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Diabetes

Musculoskeletal
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Chronic Pain

Neurologic
- ☐ Migraines
- ☐ Seizures
- ☐ TIA/Stroke

Infectious
- ☐ HIV
- ☐ Herpes
- ☐ Genital Warts
- ☐ Hepatitis C
- ☐ Hepatitis B

Renal
- ☐ Kidney Stones
- ☐ Kidney Disease

Breast
- ☐ Fibroadenoma
- ☐ Cystic Breasts
- ☐ Breast Pain
- ☐ Abnormal Mammogram

Hematology
- ☐ Anemia
- ☐ Pulmonary Embolism
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Prior blood transfusion

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar
- ☐ Schizophrenia
- ☐ ADHD
- ☐ Suicide Attempt

Gastrointestinal
- ☐ Inflammatory Bowel Disease
- ☐ Heart Burn/Reflux
- ☐ Gastric Bypass or Sleeve
- ☐ Hernia

Pulmonary
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea

Cancer
- ☐ Breast
- ☐ Cervical
- ☐ Ovarian
- ☐ Uterine
- ☐ Colon
- ☐ Skin
- ☐ Thyroid
- ☐ Other:

GYN Issues
- ☐ Fibroids
- ☐ Endometriosis
- ☐ Abnormal Pap Smears
- ☐ Interstitial Cystitis
- ☐ Recurrent UTIs
- ☐ Pelvic Infections
- ☐ Infertility
- ☐ PMS
- ☐ Low Libido
- ☐ Painful Sex

PROCEDURE AND SURGICAL HISTORY ☐ None

Procedure	Date/Year	Procedure	Date/Year

SEXUAL HISTORY:

Sexually active: Yes No

More than 1 partner in the past 6 months? Yes No

Age at first intercourse: _____

Sexual preference:

☐ Male ☐ Female ☐ Both

Have you been sexually assaulted or abused?

☐ Yes ☐ No

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Center for Uro-Gynecology and Pelvic Surgery

PFDI

Pt Name: _____

Date of Birth: _____

Today's Date: _____

Instructions: Please answer these questions by putting a 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 over the last 3 months.

1. Do you usually experience *pressure* in the lower abdomen? ☐ No; ☐ Yes
   0

   If yes, how much does this bother you?

   ☐ 1 Not at All - ☐ 2 Somewhat - ☐ 3 Moderately - ☐ 4 Quite a bit

2. Do you usually experience *heaviness or dullness* in the pelvic area? ☐ No; ☐ Yes
   0

   If yes how much does this bother you?

   ☐ 1 Not at All - ☐ 2 Somewhat - ☐ 3 Moderately - ☐ 4 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
   0

   If yes, how much does this bother you?

   ☐ 1 Not at All - ☐ 2 Somewhat - ☐ 3 Moderately - ☐ 4 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
   0

   If yes, how much does this bother you?

   ☐ 1 Not at All - ☐ 2 Somewhat - ☐ 3 Moderately - ☐ 4 Quite a bit

5. Do you usually experience a feeling of incomplete bladder emptying? ☐ No; ☐ Yes
   0

   If yes, how much does this bother you?

   ☐ 1 Not at All - ☐ 2 Somewhat - ☐ 3 Moderately - ☐ 4 Quite a bit

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Center for Uro-Gynecology and Pelvic Surgery

PFDI

Pt Name:_____

Date of Birth:_____

Today's Date:_____

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
0

If yes, how much does this bother you?
☐ 1 ☐ 2 ☐ 3 ☐ 4
Not at All - Somewhat - Moderately - Quite a bit

7. Do you feel you need to strain too hard to have a bowel movement? ☐ No; ☐ Yes
0

If yes, how much does this bother you?
☐ 1 ☐ 2 ☐ 3 ☐ 4
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
0

If yes, how much does this bother you?
☐ 1 ☐ 2 ☐ 3 ☐ 4
Not at All - Somewhat - Moderately - Quite a bit

9. Do you usually lose stool beyond your control if your stool is well formed? ☐ No; ☐ Yes
0

If yes, how much does this bother you?
☐ 1 ☐ 2 ☐ 3 ☐ 4
Not at All - Somewhat - Moderately - Quite a bit

10. Do you usually lose stool beyond your control if your stool is loose or liquid? ☐ No; ☐ Yes
0

If yes, how much does this bother you?
☐ 1 ☐ 2 ☐ 3 ☐ 4
Not at All - Somewhat - Moderately - Quite a bit

11. Do you usually lose gas from the rectum beyond your control? ☐ No; ☐ Yes
0

If yes, how much does this bother you?
☐ 1 ☐ 2 ☐ 3 ☐ 4
Not at All - Somewhat - Moderately - Quite a bit

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Center for Uro-Gynecology and Pelvic Surgery

PFDI

Pt Name:_____

Date of Birth:_____

Today's Date:_____

12. Do you usually have pain when you pass your stool? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

☐ 1 Not at All - ☐ 2 Somewhat - ☐ 3 Moderately - ☐ 4 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
0

If yes, how much does this bother you?

☐ 1 Not at All - ☐ 2 Somewhat - ☐ 3 Moderately - ☐ 4 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; ☐ Yes
0

If yes, how much does this bother you?

☐ 1 Not at All - ☐ 2 Somewhat - ☐ 3 Moderately - ☐ 4 Quite a bit

15. Do you usually experience frequent urination? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

☐ 1 Not at All - ☐ 2 Somewhat - ☐ 3 Moderately - ☐ 4 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
0

If yes, how much does this bother you?

☐ 1 Not at All - ☐ 2 Somewhat - ☐ 3 Moderately - ☐ 4 Quite a bit

17. Do you usually experience urine leakage related to coughing, sneezing, or laughing? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

☐ 1 Not at All - ☐ 2 Somewhat - ☐ 3 Moderately - ☐ 4 Quite a bit

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PFDI

Pt Name:_____

Date of Birth:_____

Today's Date:_____

18. Do you usually experience small amounts of urine leakage (that is, drops)? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

☐ 1 ☐ 2 ☐ 3 ☐ 4
Not at All - Somewhat - Moderately - Quite a bit

19. Do you usually experience difficulty emptying your bladder? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

☐ 1 ☐ 2 ☐ 3 ☐ 4
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
0

If yes, how much does this bother you?

☐ 1 ☐ 2 ☐ 3 ☐ 4
Not at All - Somewhat - Moderately - Quite a bit

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3 Day Voiding Diary

Pt Name:_____

Date of Birth:_____

Today's Date:_____

Instructions:

1) Pick three days and keep track of how many times you void and when you leak.
2) Every time that you void, put a "V" in the hour that corresponds when you void.
3) If you leak, put an "L"in the hour that corresponds to when you leak. If you leak more than once in that hour please place more "L's" below that hour.
4) Each line represents a 24-hour period

Day 1 **Date:** _____

AM Noon PM  Midnight

6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5

Day 2 **Date:** _____

AM Noon PM  Midnight

6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5

Day 3 **Date:** _____

AM Noon PM  Midnight

6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5

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Incontinence Severity Index (ISI)

Pt Name: _____

Date of Birth: _____

Appt Date: _____ Time: _____

Provider: _____

Today's Date: _____

Please answer the following 2 questions.

1. How often do you experience urinary leakage? (Please check one)

___ Never, I do not leak urine (0)

___ Less than once a month (1)

___ A few times a month (2)

___ A few times a week (3)

___ Every day and/or night (4)

2. How much urine do you lose each time? (Please check one)

___ None, I do not leak urine (0)

___ Drops (1)

___ Small Splashes (2)

___ More (3)

Thank you for answering these questions.

Score is calculated by multiplying score from question one with score from question 2

ISI score _____

ISI category (circle):

None Slight (1-2) Moderate (3-6) Severe (8-9) Very severe (12)

Center for Urogynecology and Pelvic Surgery
Christiana Care Health Systems

Center for Urogynecology and Pelvic Surgery

Current Medication List

Pt Name: _____

Date of Birth: _____

Today's Date: _____

MEDICATION	STRENGTH & AMOUNT YOU TAKE	HOW OFTEN

_____

Signature of Patient or Legal Representative

Date: _____/_____/_____

_____

Relationship to Patient, if Legal Representative

Time: _____

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Center for Urogynecology and Pelvic Surgery

Please complete this form if you have concerns about your sexual health that you would like to discuss with your provider

Decreased Sexual Desire Screener (DSDS)

Date: ____/____/____

Name: _____ DOB: _____/_____/_____ Age: _____

1. In the past, was your level of sexual desire or interest good and satisfying to you?	Yes	No
2. Has there been a decrease in your level of sexual desire or interest?	Yes	No
3. Are you bothered by your decreased level of sexual desire or interest?	Yes	No
4. Would you like your level of sexual desire or interest to increase?	Yes	No
5. Please circle all the factors that you feel may be contributing to your current decrease in sexual desire or interest:		
A. An operation, depression, injuries, or other medical condition	Yes	No
B. Medications, drugs, or alcohol you are currently taking	Yes	No
C. Pregnancy, recent childbirth, menopausal symptoms	Yes	No
D. Other sexual issues you may be having (pain, decreased arousal or orgasm)	Yes	No
E. Your partner's sexual problems	Yes	No
F. Dissatisfaction with your relationship or partner	Yes	No
G. Stress or fatigue	Yes	No

When completed, please give this form back to your health care provider.

Clayton AH,Goldfischer ER,Goldstein I, Derogatis L, Lewis-D'Agostino DJ, Pyke R.J Sex Med. 2009;6(3):730-738. Used with Permission