RE-ESTABLISH PATIENT PACKET

CHRISTIANA CARE
HEALTH SYSTEM

Center for Uro-Gynecology and Pelvic Surgery

4735 Ogletown-Stanton Road, MAP II, Suite 1208
Newark, DE 19713
Phone: (302) 623-4055 Fax: (302) 623-4056

Dear ___________________________:

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

Your appointment with___________________ is scheduled ____________________ at _________ AM / PM at the following location:

Medical Arts Pavilion (MAP) II,
Suite 1208
4735 Ogletown-Stanton Road
Newark, DE 19713

Smyrna Health & Wellness Center
100 S. Main Street,
Suite 215
Smyrna, DE 19977

Christiana Care Concord Center
161 Wilmington-West Chester Pike
Chadds Ford, PA 19317

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, found within this packet you will find a 3 DAY Bladder Diary and also a Pelvic Floor Questionnaire. These allow us to better understand your pelvic floor complaints. Instructions on how to complete these forms 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 with Blue Cross, AmeriHealth, Aetna, Coventry, TRICARE, or Keystone: 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 your insurance was not listed above and you're unsure of 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
Amanda Wardwell, NP
Matthew Fagan, MD
Leia Lavoie, PA-C
Colleen DeTurk, NP

CHRISTIANA CARE
HEALTH SYSTEM

Center for Uro-Gynecology 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 Services to release medical information to my insurance company, its intermediaries or carrier, or another physician's office. I hereby authorize 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 to 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:

Christiana Care Center for Urogynecology and Pelvic Surgery

Patient Portal Registration Form

CHRISTIANA CARE HEALTH SYSTEM

Patient Name: ______________________ **Date of Birth:** ___/___/___ **Date:** ___/___/___

By Enrolling in our Patient Portal you will have 24/7 access to:

- ✓ **Request or cancel appointments**
- ✓ **View your health records and test results**
- ✓ **View your doctor's recommendations**
- ✓ **Request your prescription refills**
- ✓ **Communicate directly and securely with your provider or office staff**

Please print clearly.

□ **YES** - Please sign me up for Patient Portal.

Personal E-mail address ______________________

***personal email address** is preferred over professional email.

*If you are a Christiana Care employee, you must use a personal email address, you cannot use your Christiana Care e-mail.

□ **NO** - I DO NOT have an email address

□ **NO** - I DO have an email address, but I'm not interested in joining the portal.

□ **NO** - I am not comfortable using my computer to access my healthcare and/or I am unfamiliar with using my computer to access the patient portal.

Patient Signature ______________________ Date/Time ____________

Please allow at least a week to receive your e-mail with instructions on how to register. Thank you!

Please note: The Christiana Care Patient Portals are changing over the next few months to better serve you. Thank you for your patience. Please note: The Christiana Care Patient Portals are changing over the next few months to better serve you. Not all records are accessible on the patient portal. Thank you for your patience.

CHRISTIANA CARE
HEALTH SYSTEM

Center for Uro-Gynecology and Pelvic Surgery

MEDICAL HISTORY UPDATE FORM

Pt Name: ____________________

Date of Birth: ____________________

Today's Date: ____________________

It has been at least 3 years since you were last seen by this office. Many things can change in that time frame so please take a few minutes to answer the following questions:

Who is your primary care doctor: ____________________
What is your preferred pharmacy: ____________________

Since you were last seen, has your medical history changed? Developed new problems or resolved old ones? Please list:

____

____

Since you were last seen, have you been pregnant or given birth?
□ NO □ YES → □ currently □ full term □ preterm □ cesarean □ miscarriage
Date(s) ____________________

Smoking Status: □ Never Smoker □ Current smoker □ Former smoker (date quit: ____________)
If Current smoker, how many packs per day: ________

Do you drink alcohol? : □ none □ socially/occasionally □ weekends □ daily
Type of alcohol: □ beer □ wine □ liquor □ all
Alcoholic drinks per day______

Do you drink caffeine? : □ none □ occasionally □ daily
Type: □ Coffee □ Tea □ Soda □ all
Caffeinated drinks per day______

Preferred learning style? □ Discussion □ Demonstration □ Handout □ Other ____________
Learning Barrier(s) □ none □ cognitive (comprehension) □ language
If yes, explain: ____________________

Marital Status: □ Single □ Married □ Divorced □ Married □ Widowed

Living Situation: □ with family □ with partner □ alone □ assisted living □ homeless

**Preferred contact number to reach you with test results: ____________________ **
Select ONE → □ DO NOT call with test results □ leave general (non-medical) message □ leave full detailed message

Employment status: □ Full Time □ Part Time □ Unemployed □ Retired □ Disabled □ Self employed
Occupation: ____________________

When was your last Pap smear: ____________ was it normal (please circle): Yes No

Since you were last seen, have you had any surgery? Please list:

____

____

____

X ____________________
Signature of Patient or Legal Representative
Date: _____/_____/__________

X ____________________
Relationship to Patient, if Legal Representative
Time: ____________________

CHRISTIANA CARE
HEALTH SYSTEM

Center for Uro-Gynecology and Pelvic Surgery

MEDICAL HISTORY UPDATE FORM

Pt Name:______________________________

Date of Birth:___________________________

Today's Date:___________________________

MEDICATION	STRENGTH & AMOUNT YOU TAKE	HOW OFTEN

X ____
Signature of Patient or Legal Representative
Date: _____/_____/______________

X______________________________
Relationship to Patient, if Legal Representative
Time: ____________________________

CHRISTIANA CARE
HEALTH SYSTEM

Center for Uro-Gynecology and Pelvic Surgery

REVIEW OF SYMPTOMS

Have you had any problems related to the following **symptoms in the past month**? Circle **Yes** or **No**

General

Symptom		
Fatigue	YES	NO
Fever	YES	NO
Feel Ill	YES	NO
Night Sweats	YES	NO
Weight gain	YES	NO
Weight loss	YES	NO

Ears, Nose & Throat

Symptom		
Hearing loss	YES	NO
Runny nose	YES	NO
Ringing in ears	YES	NO
Oral ulcers (mucositis)	YES	NO
Inflammation of mouth (i.e. Stomatitis)	YES	NO
Sore throat	YES	NO

Eyes

Symptom		
Vision changes	YES	NO

Skin

Symptom		
Hair loss (alopecia)	YES	NO
Lesions	YES	NO
Rash	YES	NO
Worrisome mole	YES	NO

Allergy/Immunologic

Symptom		
Hay fever	YES	NO
HIV exposure	YES	NO
Hives (urticaria)	YES	NO
Persistent infections	YES	NO

Breast

Symptom		
Breast lump	YES	NO

Respiratory

Symptom		
Cough	YES	NO
Short of breath while lying down (orthopnea)	YES	NO
Post nasal drip	YES	NO
Shortness of breath	YES	NO
Wheezing	YES	NO

Cardiovascular

Symptom		
Chest pain	YES	NO
Leg pain with movement (claudication)	YES	NO
Lymphedema	YES	NO
Palpitations	YES	NO
Swelling of hands/feet (peripheral edema)	YES	NO

Endocrine

Symptom		
Cold intolerance	YES	NO
Heat intolerance	YES	NO
Excessive thirst (polydipsia)	YES	NO
Excessive urination (Polyuria)	YES	NO
Night sweats	YES	NO

Heme/Lymphatic

Symptom		
Abnormal bruising	YES	NO
Abnormal bleeding	YES	NO
Enlarged lymph nodes	YES	NO

Genitourinary

Symptom		
Burning with urination (dysuria)	YES	NO
Frequent urination	YES	NO
Blood in urine (hematuria)	YES	NO
Kidney Stones	YES	NO

Female

Symptom		
Incontinence	YES	NO
Menstrual irregularity	YES	NO
Vaginal discharge	YES	NO
Vaginal dryness	YES	NO
Vaginal itching	YES	NO
Vaginal discomfort	YES	NO
Sexual dysfunction	YES	NO

Gastrointestinal

Symptom		
Abdominal Pain	YES	NO
Constipation	YES	NO
Diarrhea	YES	NO
Difficulty swallowing (dysphagia)	YES	NO
Blood in stool (melena)	YES	NO
Nausea	YES	NO
Vomiting	YES	NO

Musculoskeletal

Symptom		
Back pain	YES	NO
Neck pain	YES	NO
Joint pain	YES	NO
Stiffness	YES	NO

Psychological

Symptom		
Sleep problems	YES	NO
Depression	YES	NO
Anxiety	YES	NO
Suicidal thoughts	YES	NO
Hallucinations	YES	NO

Neurological

Symptom		
Headache	YES	NO
Weakness	YES	NO
Numbness	YES	NO
Memory loss	YES	NO
Tingling	YES	NO
Tremor	YES	NO

X ______________________________
Signature of Patient or Legal Representative
Date: _____/_____/_______________

X ______________________________
Relationship to Patient, if Legal Representative
Time: ______________________________

CHRISTIANA CARE
HEALTH SYSTEM

Center for Uro-Gynecology and Pelvic Surgery

Incontinence Severity Index (ISI)

Pt Name:________________________

Date of Birth:________________________

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

CHRISTIANA CARE
HEALTH SYSTEM

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

CHRISTIANA CARE
HEALTH SYSTEM

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

CHRISTIANA CARE
HEALTH SYSTEM

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 ☐ 2 ☐ 3 ☐ 4
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
0

If yes, how much does this bother you?

☐ 1 ☐ 2 ☐ 3 ☐ 4
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; ☐ Yes
0

If yes, how much does this bother you?

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

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

If yes, how much does this bother you?

☐ 1 ☐ 2 ☐ 3 ☐ 4
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
0

If yes, how much does this bother you?

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

CHRISTIANA CARE
HEALTH SYSTEM

Center for Uro-Gynecology and Pelvic Surgery

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

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

If yes, how much does this bother you?

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

CHRISTIANA CARE
HEALTH SYSTEM

Center for Uro-Gynecology and Pelvic Surgery

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