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

Matthew Fagan, MD
Leia Lavoie, PA-C
Colleen DeTurk, NP
Amanda Wardwell, NP
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) ____________________________ (Middle) ________________ 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 ____________________________ Date ____________________________
Signature of Patient or Legal Representative Relationship to Patient, If Legal Representative 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 ____________________________ Date ____________________________
Interpreter Name / Agency ID # Staff signature/Title, Date ____________________________ Time ____________________________
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.
Center for Uro-Gynecology and Pelvic Surgery

Patient Name: __________________________ Date of Birth: __________ / ______ / ______
Primary Care Physician: (name & phone #) __________________________
Referring Physician (if different from PCP) (name & phone #) __________________________
Preferred Pharmacy (name & location or phone #) __________________________

PAST MEDICAL HISTORY (Please Circle all that apply)

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<td>Cancer</td>
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Type of Cancer: __________________________

SURGERIES: (Please list any surgeries you’ve had and approximate date)

MEDICATION ALLERGIES: (Please list all allergies. IF NO ALLERGIES, please write “NONE”)

Learning Style: □ Discussion □ Demonstration □ Handout □ Other __________________________
Learning Barrier(S): □ none □ cognitive (comprehension) □ memory □ language __________________________

Tobacco Use: □ YES □ NO

ALCOHOL USE:

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<th>Drinks/day?</th>
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CAFFEINE INTAKE:

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<th>Cup(s)/day</th>
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<th>□ NO</th>
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DRUG USE:

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<th>Type</th>
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2ND HAND SMOKE EXPOSURE: □ YES □ NO

DOMESTIC VIOLENCE: □ YES □ NO

MARRITAL STATUS: □ Single □ Divorced □ Married □ Widowed

LIVING SITUATION: □ with Family □ with Partner □ Alone □ Assisted Living □ Homeless

OCCUPATION: □ Full Time □ Part-Time □ Retired □ Unemployed □ Disabled

FAMILY HISTORY (Please circle all that pertain and describe who the relative is)

Mother: Alive □ Deceased □ Health Problems: Diabetes □ Heart Disease □ Cancer (type): __________
Father: Alive □ Deceased □ Health Problems: Diabetes □ Heart Disease □ Cancer (type): __________
Brother: Alive □ Deceased □ Health Problems: Diabetes □ Heart Disease □ Cancer (type): __________
Sister: Alive □ Deceased □ Health Problems: Diabetes □ Heart Disease □ Cancer (type): __________

Other family history:

PAST OBSTETRICAL/GYNECOLOGICAL HISTORY:

Contraception (circle all that apply): □ None □ Abstinence □ Tubal □ Vasectomy □ Pills □ IUD □ Condoms □ Other: __________

Last Pap smear NORMAL? (Circle): □ Yes □ No Date of last Pap smear: __________

#Total Pregnancies: __________, #Full-term: __________, #Preterm: __________, #Cesarean: __________, #Miscarriage/Abortion: __________, Total # living: __________

**Preferred contact number to reach you with test results:** __________________________

Select ONE □ do not call with test results □ Okay to leave general message □ Okay to leave detailed message

X __________________________

Signature of Patient or Legal Representative __________________________

Date: / / ______

Relationship to Patient, if Legal Representative __________________________

Time: / ______ ______ ______
Center for Uro-Gynecology and Pelvic Surgery
Current Medication List

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<th>MEDICATION</th>
<th>STRENGTH &amp; AMOUNT YOU TAKE</th>
<th>HOW OFTEN</th>
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Signature of Patient or Legal Representative
Date: __/__/____________

Relationship to Patient, if Legal Representative
Time: ________________
### REVIEW OF SYMPTOMS

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

#### General
- Fatigue
- Fever
- Feel Ill
- Night Sweats
- Weight gain
- Weight loss

#### Cardiovascular
- Chest pain
- Leg pain with movement (claudication)
- Lymphedema
- Palpitations
- Swelling of hands/feet (peripheral edema)

#### Gastrointestinal
- Abdominal Pain
- Constipation
- Diarrhea
- Difficulty swallowing (dysphagia)
- Blood in stool (melena)
- Nausea
- Vomiting

#### Ears, Nose & Throat
- Hearing loss
- Runny nose
- Ringing in ears
- Oral ulcers (mucositis)
- Inflammation of mouth (i.e. Stomatitis)
- Sore throat

#### Endocrine
- Cold intolerance
- Heat intolerance
- Excessive thirst (polydipsia)
- Excessive urination (Polyuria)
- Night sweats

#### Musculoskeletal
- Back pain
- Neck pain
- Joint pain
- Stiffness

#### Skin
- Hair loss (alopecia)
- Lesions
- Rash
- Worrisome mole

#### Allergy/Immunologic
- Hay fever
- HIV exposure
- Hives (urticaria)
- Persistent infections

#### Eyes
- Vision changes

#### Heme/Lymphatic
- Abnormal bruising
- Abnormal bleeding
- Enlarged lymph nodes

#### Psychological
- Sleep problems
- Depression
- Anxiety
- Suicidal thoughts
- Hallucinations

#### Genitourinary
- Burning with urination (dysuria)
- Frequent urination
- Blood in urine (hematuria)
- Kidney Stones

#### Neurological
- Headache
- Weakness
- Numbness
- Memory loss
- Tingling
- Tremor

#### Respiratory
- Cough
- Short of breath while lying down (orthopnea)
- Post nasal drip
- Shortness of breath
- Wheezing

#### Female
- Incontinence
- Menstrual irregularity
- Vaginal discharge
- Vaginal dryness
- Vaginal itching
- Vaginal discomfort
- Sexual dysfunction

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**Signature of Patient or Legal Representative**

**Date:** / / 

**Relationship to Patient, if Legal Representative**

**Time:**
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)
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?  
   If yes, how much does this bother you?  
   □ 1  □ 2  □ 3  □ 4  
   Not at All - Somewhat - Moderately - Quite a bit
   □ No; □ Yes

2. Do you usually experience heaviness or dullness in the pelvic area?  
   If yes, how much does this bother you?  
   □ 1  □ 2  □ 3  □ 4  
   Not at All - Somewhat - Moderately - Quite a bit
   □ No; □ Yes

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?  
   □ 1  □ 2  □ 3  □ 4  
   Not at All - Somewhat - Moderately - Quite a bit
   □ No; □ Yes

4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?  
   If yes, how much does this bother you?  
   □ 1  □ 2  □ 3  □ 4  
   Not at All - Somewhat - Moderately - Quite a bit
   □ No; □ Yes

5. Do you usually experience a feeling of incomplete bladder emptying?  
   If yes, how much does this bother you?  
   □ 1  □ 2  □ 3  □ 4  
   Not at All - Somewhat - Moderately - Quite a bit
   □ No; □ Yes
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
   □ 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
   □ 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
   □ 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
   □ 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
    □ 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
    □ 1  □ 2  □ 3  □ 4
    Not at All - Somewhat - Moderately - Quite a bit
12. Do you usually have pain when you pass your stool?
   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?
   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?
   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?
   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?
   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?
   If yes, how much does this bother you?
   □ 1  □ 2  □ 3  □ 4
   Not at All - Somewhat - Moderately - Quite a bit
18. Do you usually experience small amounts of urine leakage (that is, drops)?
   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?
   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?
    If yes, how much does this bother you?
    □ 1 □ 2 □ 3 □ 4
    Not at All - Somewhat - Moderately - Quite a bit
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: ________________

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