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
Center for Uro-Gynecology and Pelvic Surgery

Patient Registration

Patient Name: ___________________________ (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: ___________________________ (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, Date Time:
If Legal Representative

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:
Patient Portal Registration Form

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.
Pt Name: ______________________
Date of Birth: ______________________

MEDICAL HISTORY UPDATE FORM

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: ______________________
Pt Name: 
Date of Birth: 
Today's Date: 

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>STRENGTH &amp; AMOUNT YOU TAKE</th>
<th>HOW OFTEN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>General</th>
<th>Cardiovascular</th>
<th>Gastrointestinal</th>
<th>Endocrine</th>
<th>Musculoskeletal</th>
<th>Psychological</th>
<th>Neurological</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatigue</td>
<td>Chest pain</td>
<td>Abdominal Pain</td>
<td>Cold intolerance</td>
<td>Back pain</td>
<td>Sleep problems</td>
<td>Headache</td>
</tr>
<tr>
<td>Fever</td>
<td>Leg pain with movement</td>
<td>Constipation</td>
<td>Heat intolerance</td>
<td>Neck pain</td>
<td>Depression</td>
<td>Weakness</td>
</tr>
<tr>
<td>Feel Ill</td>
<td>(claudication)</td>
<td>Diarrhea</td>
<td>Excessive thirst (polydipsia)</td>
<td>Joint pain</td>
<td>Anxiety</td>
<td>Numbness</td>
</tr>
<tr>
<td>Night Sweats</td>
<td>Lymphedema</td>
<td>Difficulty swallowing</td>
<td>Excessive urination (Polyuria)</td>
<td>Stiffness</td>
<td>Suicidal thoughts</td>
<td>Memory loss</td>
</tr>
<tr>
<td>Weight gain</td>
<td>Palpitations</td>
<td>Blood in stool (melena)</td>
<td>Night sweats</td>
<td></td>
<td>Hallucinations</td>
<td>Tingling</td>
</tr>
<tr>
<td>Weight loss</td>
<td>Swelling of hands/feet</td>
<td>Nausea</td>
<td></td>
<td></td>
<td></td>
<td>Tremor</td>
</tr>
</tbody>
</table>

(Peripheral edema)

<table>
<thead>
<tr>
<th>Ears, Nose &amp; Throat</th>
<th>Heme/Lymphatic</th>
<th>Psychological</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing loss</td>
<td>Abnormal bruising</td>
<td>Sleep problems</td>
</tr>
<tr>
<td>Runny nose</td>
<td>Abnormal bleeding</td>
<td>Depression</td>
</tr>
<tr>
<td>Ringing in ears</td>
<td>Enlarged lymph nodes</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Oral ulcers (mucositis)</td>
<td></td>
<td>Suicidal thoughts</td>
</tr>
<tr>
<td>Inflammation of mouth</td>
<td></td>
<td>Hallucinations</td>
</tr>
<tr>
<td>(i.e. Stomatitis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sore throat</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eyes</th>
<th>Genitourinary</th>
<th>Neurological</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision changes</td>
<td>Burning with urination (dysuria)</td>
<td>Headache</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skin</th>
<th>Female</th>
<th>Neurological</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hair loss (alopecia)</td>
<td>Incontinence</td>
<td>Headache</td>
</tr>
<tr>
<td>Lesions</td>
<td>Menstrual irregularity</td>
<td>Weakness</td>
</tr>
<tr>
<td>Rash</td>
<td>Vaginal discharge</td>
<td>Numbness</td>
</tr>
<tr>
<td>Worrisome mole</td>
<td>Vaginal dryness</td>
<td>Memory loss</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Allergy/Immunologic</th>
<th>Vaginal itching</th>
<th>Tingling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hay fever</td>
<td>Vaginal discomfort</td>
<td>Tremor</td>
</tr>
<tr>
<td>HIV exposure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hives (urticaria)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistent infections</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Breast</th>
<th>Female</th>
<th>Neurological</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast lump</td>
<td>Incontinence</td>
<td>Headache</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respiratory</th>
<th>Female</th>
<th>Neurological</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cough</td>
<td>Menstrual irregularity</td>
<td>Weakness</td>
</tr>
<tr>
<td>Short of breath while lying down (orthopnea)</td>
<td>Vaginal discharge</td>
<td>Numbness</td>
</tr>
<tr>
<td>Post nasal drip</td>
<td>Vaginal dryness</td>
<td>Memory loss</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>Vaginal itching</td>
<td>Tingling</td>
</tr>
<tr>
<td>Wheezing</td>
<td>Vaginal discomfort</td>
<td>Tremor</td>
</tr>
</tbody>
</table>

| | Sexual dysfunction | |
| | | |

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

2. Do you usually experience heaviness or dullness in the pelvic area?
   □ No; □ Yes
   □ 1 □ 2 □ 3 □ 4
   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
   □ 1 □ 2 □ 3 □ 4
   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
   □ 1 □ 2 □ 3 □ 4
   Not at All - Somewhat - Moderately - Quite a bit

5. Do you usually experience a feeling of incomplete bladder emptying?
   □ No; □ Yes
   □ 1 □ 2 □ 3 □ 4
   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?  
If yes, how much does this bother you?  
☐ 1 2 3 4  
Not at All - Somewhat - Moderately - Quite a bit  
☐ No; ☐ Yes

7. Do you feel you need to strain too hard 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  
☐ No; ☐ Yes

8. Do you feel you have not completely emptied your bowels at the end of 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

9. Do you usually lose stool beyond your control if your stool is well formed?  
If yes, how much does this bother you?  
☐ 1 2 3 4  
Not at All - Somewhat - Moderately - Quite a bit  
☐ No; ☐ Yes

10. Do you usually lose stool beyond your control if your stool is loose or liquid?  
If yes, how much does this bother you?  
☐ 1 2 3 4  
Not at All - Somewhat - Moderately - Quite a bit  
☐ No; ☐ Yes

11. Do you usually lose gas from the rectum beyond your control?  
If yes, how much does this bother you?  
☐ 1 2 3 4  
Not at All - Somewhat - Moderately - Quite a bit  
☐ No; ☐ Yes
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
   □ No; □ Yes

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
   □ No; □ Yes

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
   □ No; □ Yes
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: ____________

<table>
<thead>
<tr>
<th>AM</th>
<th>Noon</th>
<th>PM</th>
<th>Midnight</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td>11</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td>11</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Day 2 Date: ____________

<table>
<thead>
<tr>
<th>AM</th>
<th>Noon</th>
<th>PM</th>
<th>Midnight</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td>11</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td>11</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Day 3 Date: ____________

<table>
<thead>
<tr>
<th>AM</th>
<th>Noon</th>
<th>PM</th>
<th>Midnight</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td>11</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td>11</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>