We are looking forward to your upcoming visit with us. Our goal is to provide you with outstanding care.

In order to facilitate your visit, please complete the following forms before your scheduled appointment. These forms will be collected at check-in.

Please arrive 10 minutes prior to your appointment with this paperwork so that we can better serve you. If you arrive past your appointment time, we may need to reschedule your visit.

If you have any questions prior to your visit, please contact the respective office at the number listed below.

**Raleigh | UNC Urogynecology and Reconstructive Pelvic Surgery at Rex**

4325 Lake Boone Trail  
Suite 315  
Raleigh, NC 27607

919-882-0896 | Appointments  
919-882-0591 | Fax

**Hillsborough | UNC Urogynecology and Reconstructive Pelvic Surgery at Hillsborough**

460 Waterstone Drive  
Third Floor  
Hillsborough, NC 27278

919-595-5929 | Appointments  
919-595-5641 | Fax

Additional information about our practice and our providers can be found at:

[www.UNCurogyn.org](http://www.UNCurogyn.org)
At **UNC Urogynecology and Reconstructive Pelvic Surgery**, we believe that team-based medicine provides patients with outstanding care and greater access to resources. Our multi-disciplinary team consists of medical assistants, nurses, nurse practitioners, physician assistants, and physicians at various levels of training.

Members of your care team may include:

**Residents:** After completion of medical school, an individual becomes a “doctor.” However, she or he needs to undergo specialty training to develop the practical skill set necessary to practice medicine, and this training process is called “residency”. UNC has one of the nation’s top OB-GYN residency programs. Our residents are fully supervised and enhance our ability to care for women with pelvic floor disorders. Completion of residency enables a doctor to become an independent, licensed, board certified physician.

**Fellows:** When physicians choose to sub-specialize within OB-GYN, they complete a fellowship. Fellows in Female Pelvic Medicine and Reconstructive Surgery (FPRMS), also called Urogynecology, are passionate about caring for women with pelvic floor disorders. Fellows at UNC Urogynecology and Reconstructive Pelvic Surgery focus on advanced office practice and surgical training; they are also actively engage in the latest research which allows them to provide cutting-edge health care services. Fellows are licensed physicians who are supervised by and work as colleagues with attending physicians.

**Nurse Practitioner:** Nurse Practitioners (NP) complete a master’s or doctoral graduate degree program, and have advanced clinical training beyond their initial registered nurse preparation. Similar to physicians, NPs pass a national board certification exam and are licensed in their state. NPs are able to provide a full range of primary, acute and specialty health care services autonomously, and in collaboration with physicians.

**Attending physician:** An attending physician has completed specialized training and is an independent, licensed, board certified Female Pelvic Medicine and Reconstructive Surgery physician. The attending supervises the entire medical team.

**UNC Urogynecology and Reconstructive Pelvic Surgery** is committed to providing quality care for women with pelvic floor disorders. We follow the University of North Carolina’s anti-discrimination statement and do not discriminate based on age, race, religion or gender.

We are a multidisciplinary team serving not only the Raleigh/Durham/Chapel Hill area, but also the entire state of North Carolina. We provide comprehensive care with providers who have advanced specialty training in Urogynecology and Reconstructive Pelvic Surgery. We are committed to training fellows, residents and medical students of all ages, races, religions, and genders to become competent care providers for women with pelvic floor disorders. When you receive care at the UNC Urogynecology, you will have a team that may include attending physicians, fellows, nurse practitioners, residents, nurses, and medical students, all of whom work as a team to provide outstanding care. All care is ultimately supervised by an attending physician. We have providers of all ages, races, religions and genders, and given our team approach, you may not see the same provider at all of your visits. This allows us to focus on providing you with high-quality, compassionate medical care.

We look forward to meeting you and working with you.
## Patient Information

### Referring Physician
Name: 
Address: 
City: State: Zip: 
Phone: 

### Patient Name
Date of Birth: Age: 

### Primary Care Physician
Name: 
Address: 
City: State: Zip: 
Phone: 

### Pharmacy
Name: 
Address: 
City: State: Zip: 
Phone: 

### Today's Visit
What is the main reason you came to the office today?

What is your most bothersome symptom or concern?

What are your expectations for treatment?

### Urinary Incontinence
- **Do you leak urine?**
  - Yes [ ]  No [ ]
  - When did it start?
- **How often do you leak urine?**
  - ____ times per day  ____ times per week  Every ____ weeks
- **Do you leak urine when you cough, sneeze, or laugh?**
  - Yes [ ]  No [ ]
  - Prior treatment?
- **Do you leak urine with urge or on the way to the bathroom?**
  - Yes [ ]  No [ ]
  - Prior treatment?
- **Please check if you leak urine during the following activities:**
  - Walking [ ]  Running [ ]  Exercise [ ]  Straining or lifting [ ]  Going from sitting to standing [ ]  With Intercourse [ ]  With minimal activity [ ]  With Urgency [ ]
- **Do you use a pad for urine leakage?**
  - Yes [ ]  No [ ]
  - How many per day? ____
  - Mini pad [ ]  Pad [ ]  Adult Diaper [ ]

### Urinary Frequency / Urgency
- **Do you usually experience frequent urination?**
  - Yes [ ]  No [ ]
- **Do you usually experience urinary urgency?**
  - Yes [ ]  No [ ]
- **How many times do you urinate during the day?_____**
- **How many times do you get up during the night to urinate?_______**
- **Do you wet the bed while sleeping?**
  - Yes [ ]  No [ ]
Urination Difficulty
Do you find it hard to begin urinating?  □ Yes □ No
Do you ever have to push up on a bulge in the vaginal area to start or complete urination?  □ Yes □ No
After emptying your bladder do you have the feeling that you have not finished?  □ Yes □ No
Have you ever needed to use a catheter to empty your bladder?  □ Yes □ No If yes, when________________________

Urinary Tract Infections / Kidney Stones
Number of urinary tract infections in the last year______ Was a urine culture sent each time?  □ Yes □ No
Have you had blood in your urine?  □ Yes □ No  If yes, could you see the blood in your urine?  □ Yes □ No
Have you ever had kidney stones?  □ Yes □ No  Have you ever had a kidney infection (pyelonephritis)?  □ Yes □ No

Pelvic Organ Prolapse Symptoms
Do you feel a bulge or something falling out of the vagina?  □ Yes □ No  Do you see a bulge in the vagina?  □ Yes □ No
If you feel or see a bulge, is it bothersome?  □ Yes □ No  Have you had any prior treatment for bulging?  □ Yes □ No

Bowel Symptoms
How often do you have a bowel movement?  □ Every day □ ____ times per day □ ____ times per week □ Every ____ weeks
What is the consistency of your stools?  □ Hard □ Soft □ Loose
Do you typically experience:  □ Diarrhea □ Constipation □ Laxative Use
Diarrhea □ Yes □ No  Solid stool □ Yes □ No How often:________________________
Constipation □ Yes □ No  Liquid stool □ Yes □ No How often:________________________
Laxative Use □ Yes □ No  Gas □ Yes □ No How often:________________________

What is your bowel regimen?  □ Diet-controlled □ Fiber □ Stool Softener □ Miralax □ Other________________________
Do you feel that you need to strain too hard to have a bowel movement?  □ Yes □ No
Do you ever have to push on the vagina or around the rectum to have or complete a bowel movement?  □ Yes □ No
Do you feel that you have not completely emptied your bowels at the end of a bowel movement?  □ Yes □ No
Do you have a strong sense of urgency and have to rush to the bathroom to have a bowel movement?  □ Yes □ No

Medical History  Please list all current medical conditions you have:
1. __________________________________________  5. ________________________________
2. __________________________________________  6. ________________________________
3. __________________________________________  7. ________________________________
4. __________________________________________  8. ________________________________

Surgical History  Please list all past surgeries and the date of the surgery:
1. __________________________________________  4. ________________________________
2. __________________________________________  5. ________________________________
3. __________________________________________  6. ________________________________
Past Obstetrical History
How many times have you been pregnant? ________  Weight of largest child ________
Of these, how many were: Vaginal deliveries ________  Forceps or vacuum deliveries ________
Cesarean deliveries ________  Miscarriages ________  Abortions ________
Any complications? __________________________________________

Past Gynecological History
Have you gone through menopause? □ Yes □ No  If no, when was your last menstrual period? ____________________________
Are you sexually active? □ Yes □ No  If no, why? __________________________________________
Do you have pain with intercourse? □ Yes □ No  If yes, describe: __________________________________________
What do you use for contraception? □ N/A □ Pills □ IUD □ Diaphragm □ Condoms □ Tubes Tied □ Vasectomy
Last Pap Test: Date ________  Results ________  Last Colonoscopy: Date ________  Results ________
Please check any of the following that you currently have or used to have:
□ Heavy or irregular bleeding □ Abnormal pap smear □ Ovarian cysts or tumors □ Uterine Fibroids
□ Sexually transmitted infection (gonorrhea, chlamydia, herpes, etc): __________________________
□ Other __________________________________________

Please list or attach a list of your current medications, dose, and how often you take them (this includes birth control and hormone replacement meds). Also include any vitamins or herbal supplements you are taking as well:

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<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency (schedule)</th>
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Please list any allergies (food, medications, etc.) and your reaction to them:

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<tr>
<th>Allergy</th>
<th>Reaction</th>
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Social History
Are you? □ Single □ Married □ Divorced □ Widowed □ Unmarried with partner
Who do you live with? __________________________________________
Do you work now? □ Yes □ No  What is your current or most recent job? ____________________________
Do you exercise? □ Yes □ No  If yes, describe ____________________________
Do you smoke? □ Yes □ No  If yes, how many per day? ________  Would you like help to quit smoking? □ Yes □ No
How often do you drink alcohol? □ Daily □ Weekly □ Occasionally □ Never

FORM DATE 07-28-15  CHART LOCATION: PATIENT QUESTIONNAIRE
Do you use any illegal drugs? □ Yes □ No If yes, please list: ________________________________________________________________

Have you ever been emotionally, physically, or sexually abused? □ Yes □ No If yes, when? ______________________________________________

**Family History**

Have any of your relatives had any of the following medical conditions?

- **Heart attack** □ Yes □ No Who? __________________________________________
- **Bleeding disorder** □ Yes □ No Who? _______________________________________
- **Clotting disorder** □ Yes □ No Who? (e.g. DVT – deep venous thrombosis, PE – pulmonary embolism)
- **Colon Cancer** □ Yes □ No Who? _________________________________________
- **Gynecologic Cancer** □ Yes □ No Who? (e.g. uterine/endometrial, ovarian, cervical)
- **Bladder or Kidney Cancer** □ Yes □ No Who? _____________________________
- **Breast Cancer** □ Yes □ No Who? _______________________________________

**Please indicate whether any of the following are currently a concern for you**

### General
- □ Yes □ No Excessive fatigue
- □ Yes □ No Weight loss

### Heart
- □ Yes □ No Chest pain
- □ Yes □ No Heart palpitations (irregular heart beat)
- □ Yes □ No Discomfort in chest with exercise or walking

### Lungs
- □ Yes □ No Shortness of breath
- □ Yes □ No Cough

### Gastrointestinal
- □ Yes □ No Frequent nausea and / or vomiting
- □ Yes □ No Heartburn

### Gastrointestinal
- □ Yes □ No Joint pain
- □ Yes □ No Back pain

### Skin
- □ Yes □ No Rashes
- □ Yes □ No Moles that have changed in color or size

### Neurologic
- □ Yes □ No Frequent or severe headaches
- □ Yes □ No Dizziness

### Psychiatric
- □ Yes □ No Depression
- □ Yes □ No Anxiety
- □ Yes □ No Thoughts of harming yourself or others

### Hematologic
- □ Yes □ No Easy bruising
- □ Yes □ No Blood clots in your legs or lungs
**Pelvic Floor Distress Inventory (PFDI) – Short Form 20**

**Pelvic Organ Prolapse Distress Inventory (POPDI-6)**

Do you usually experience *pressure* in the lower abdomen?
- No
- If yes, how bothersome is it: Not at all, Somewhat, Moderately, Quite a bit

Do you usually experience *heaviness or dullness* in the pelvic area?
- No
- If yes, how bothersome is it: Not at all, Somewhat, Moderately, Quite a bit

Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?
- No
- If yes, how bothersome is it: Not at all, Somewhat, Moderately, Quite a bit

Do you ever have to push on the vagina or around the rectum to have or complete a bowel movement?
- No
- If yes, how bothersome is it: Not at all, Somewhat, Moderately, Quite a bit

Do you usually experience a feeling of incomplete bladder emptying?
- No
- If yes, how bothersome is it: Not at all, Somewhat, Moderately, Quite a bit

Do you ever have to push up on a bulge in the vaginal area with your fingers to start of complete urination?
- No
- If yes, how bothersome is it: Not at all, Somewhat, Moderately, Quite a bit

**Colorectal-Anal Distress Inventory (CRADI-8)**

Do you feel that you need to strain too hard to have a bowel movement?
- No
- If yes, how bothersome is it: Not at all, Somewhat, Moderately, Quite a bit

Do you feel that you have not completely emptied your bowels at the end of a bowel movement?
- No
- If yes, how bothersome is it: Not at all, Somewhat, Moderately, Quite a bit

Do you usually lose stool beyond your control if your stool is well-formed?
- No
- If yes, how bothersome is it: Not at all, Somewhat, Moderately, Quite a bit

Do you usually lose stool beyond your control if your stool is loose?
- No
- If yes, how bothersome is it: Not at all, Somewhat, Moderately, Quite a bit

Do you usually lose gas from the rectum beyond your control?
- No
- If yes, how bothersome is it: Not at all, Somewhat, Moderately, Quite a bit

Do you usually have pain when you pass your stool?
- No
- If yes, how bothersome is it: Not at all, Somewhat, Moderately, Quite a bit

Do you usually experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?
- No
- If yes, how bothersome is it: Not at all, Somewhat, Moderately, Quite a bit

Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?
- No
- If yes, how bothersome is it: Not at all, Somewhat, Moderately, Quite a bit

*Please Continue to Next Page...*
Urinary Distress Inventory (UDI-6)

Do you usually experience frequent urination?

☐ No If yes, how bothersome is it:  ☐ Not at all, ☐ Somewhat, ☐ Moderately, ☐ Quite a bit

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 bothersome is it:  ☐ Not at all, ☐ Somewhat, ☐ Moderately, ☐ Quite a bit

Do you usually experience urine leakage related to coughing, sneezing or laughing?

☐ No If yes, how bothersome is it:  ☐ Not at all, ☐ Somewhat, ☐ Moderately, ☐ Quite a bit

Do you usually experience urine leakage related to coughing, sneezing or laughing?

☐ No If yes, how bothersome is it:  ☐ Not at all, ☐ Somewhat, ☐ Moderately, ☐ Quite a bit

Do you usually experience small amounts of leakage or urine (that is, drops)?

☐ No If yes, how bothersome is it:  ☐ Not at all, ☐ Somewhat, ☐ Moderately, ☐ Quite a bit

Do you usually experience difficulty emptying your bladder?

☐ No If yes, how bothersome is it:  ☐ Not at all, ☐ Somewhat, ☐ Moderately, ☐ Quite a bit

Do you usually experience pain or discomfort in the lower abdomen or genital region?

☐ No If yes, how bothersome is it:  ☐ Not at all, ☐ Somewhat, ☐ Moderately, ☐ Quite a bit

Patient Signature_________________________________________ Date________________________

Printed Name______________________________________________