UNC HEALTH CARE
WOMEN'S CARE

UNC Pelvic Health
Division of Female Pelvic Medicine and Reconstructive Surgery
New Patient Packet

We are looking forward to your upcoming visit with us.

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

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

Chapel Hill | N.C. Women's Hospital

Nurse Line | 919-445-7222

Scheduling | 919-843-1592

Hillsborough | UNC Hillsborough Campus

Nurse Line | 919-595-5930

Scheduling | 919-843-1592

Raleigh | UNC Pelvic Health Center at Rex

Nurse Line | 919-882-0808

Scheduling | 919-882-0896

www.UNCpelvichealth.org

Patient Information

Referring Physician:

Name_____

Address_____

City_____State_____Zip_____

Phone_____

Patient Name:_____

Birthday:_____ **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/day ☐ ____ times/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 frequently 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/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 Could you see the blood? ☐ Yes ☐ No

Have you ever had kidney stones? ☐ Yes ☐ No Have you ever had a kidney infection (pyelonephritis)? ☐ Yes ☐ No

Prolapse Symptoms

Do you feel a bulge or something fall 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/day ☐____ times/week ☐ Every ____ weeks

What is the consistency of your stools? ☐ Hard ☐ Soft ☐ Loose

Do you typically experience:

Diarrhea ☐ Yes ☐ No

Constipation ☐ Yes ☐ No

Laxative Use ☐ Yes ☐ No

Do you leak stool? ☐ Yes ☐ No, if yes what kind:

Solid stool ☐ Yes ☐ No How often:_____

Liquid stool ☐ Yes ☐ No How often:_____

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_____

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:

Medication	**Dose**	**Frequency *(schedule)***

Please list any allergies (food, medications, etc.) and your reaction to them:

Allergy	**Reaction**

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

Do you use any illegal drugs? ☐ Yes ☐ No If yes, please list:_____

Have you ever been emotionally, physically, or sexually abused? ☐ Yes ☐ No 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

Musculoskeletal
☐ 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
(e.g. DVT or PE)

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

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 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

Baseline

Pelvic Floor Impact Questionnaire – short form 7

How do the following symptoms or conditions affect your ability to do the following actions and activities?	**Bladder/Urine**	**Bowel/Rectum**	**Vagina/Pelvis**
Ability to do household chores (cooking, housecleaning, laundry)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
Ability to do physical activities such as walking, swimming, or other exercise?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
Entertainment activities such as going to a movie or concert?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
Ability to travel by car or bus for a distance greater than 30 minutes away from home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
Participating in social activities outside your home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
Emotional health (nervousness, depression, etc.)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
Feeling frustrated?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire (PISQ-12)

Following are a list of questions about you and your partner's sex life. All information is strictly confidential. Your confidential answered will be used only to help doctors understand what is important to patients about their sex lives. Please check the box that best answers the question for you.

1. How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex, feeling frustrated due to lack of sex, etc.
   ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

2. Do you climax (have an orgasm) when having sexual intercourse with your partner?
   ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

3. Do you feel sexually excited (turned on) when having sexual activity with your partner?
   ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

4. How satisfied are you with the variety of sexual activities in your current sex life?
   ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

5. Do you feel pain during sexual intercourse?
   ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

6. Are you incontinent of urine (leak urine) with sexual activity?
   ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

7. Does fear of incontinence (either stool or urine) restrict your sexual activity?
   ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

8. Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum, or vagina falling out?)?
   ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

9. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame, or guilt?
   ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

10. Does your partner have a problem with erections that affects your sexual activity?
    ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

11. Does your partner have a problem with premature ejaculation that affects your sexual activity?
    ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

12. Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?
    ☐ Much less intense ☐ Less intense ☐ Same intensity ☐ More intense ☐ Much more intense