UNC Urogynecology and Reconstructive Pelvic Surgery
Division of Female Pelvic Medicine and Reconstructive Surgery (FPMRS)

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
4325 Lake Boone Trail
Suite 315
Raleigh, NC 27607
919-882-0896 | Appointments
919-882-0591 | Fax

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
Meet Our Team

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
Where or how did you first learn about our practice?

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 □ 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

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

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

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

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

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

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

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

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

### Hematologic
- **Yes** □  **No** □ Easy bruising
- **Yes** □  **No** □ Blood clots in your legs or lungs

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

### 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? __________________________________________________________
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

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

Medical History  Please list all current medical conditions you have:

1.  
2.  
3.  
4.  
5.  
6.  
7.  
8.  

Surgical History  Please list all past surgeries and the date of the surgery:

1.  
2.  
3.  
4.  
5.  
6.  

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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<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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<th>Allergy</th>
<th>Reaction</th>
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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:
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?

Patient Signature_________________________  Date_____________________  

Printed Name_____________________________
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 or 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