



**PATIENT INFORMATION  
SHEET**

<b>PATIENT INFORMATION:</b>					
Last Name:		First Name:		Date of Birth:	
Address:		City:		State:	Zip:
Home Phone:		Cell Phone:			
E-Mail Address:					
Employer:		Occupation:		Work Phone:	
Social Security Number:					
Primary Language:		Ethnic Origin:		Race:	
<b>EMERGENCY CONTACT INFORMATION:</b>					
Name:		Relationship:		Phone:	
<b>PRIMARY INSURANCE:</b>					
POLICY HOLDER					
Last Name:		First Name:		Date of Birth:	
Address:		City:		State:	Zip:
Relationship to Patient:		Social Security Number:			
Employer:		Employer Phone Number:			
Address:		City:		State:	Zip:
Insurance Name:					
Address:		City:		State:	Zip:
Insurance ID#:		Group #:			
<b>SECONDARY INSURANCE:</b>					
POLICY HOLDER					
Last Name:		First Name:		Date of Birth:	
Address:		City:		State:	Zip:
Relationship to Patient:		Social Security Number:			
Employer:		Employer Phone Number:			
Address:		City:		State:	Zip:
Insurance Name:					
Address:		City:		State:	Zip:
Insurance ID#:		Group #:			



**Atlantic  
Health System**

**PATIENT INFORMATION  
SHEET**

<b>MEDICAL PROVIDER INFORMATION:</b>			
Name:			
Primary Care Physician:			
Address:	City:	State:	Zip:
Phone Number:	Fax Number:		
Referring Physician:			
Address:	City:	State:	Zip:
Phone Number:	Fax Number:		



PATIENT QUESTIONNAIRE

Date of Appointment: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Number of Pregnancies: \_\_\_\_\_ Number of Vaginal Births: \_\_\_\_\_ Number of C-Sections: \_\_\_\_\_

Weight of Largest Baby: \_\_\_\_\_ Form of Birth Control: \_\_\_\_\_ Date LMP: \_\_\_\_\_ Age at Menopause: \_\_\_\_\_

Do you smoke?  yes  no \_\_\_\_\_ packs per day Do you drink alcohol?  yes  no \_\_\_\_\_ drinks per day

Listed below are a series of questions regarding your bowel, bladder or pelvic symptoms, as well as your degree of discomfort, if any. Using the "key" - in the gray box - please place an X next to the appropriate number for each question below. While answering these questions, please consider your symptoms **over the last 3 months**.

KEY:
1 - Not at All
2 - Somewhat
3 - Moderately
4 - Quite a Bit

1. Do you experience pressure in the lower abdomen?  yes  no
If yes, how much does it bother you?  1  2  3  4

2. Do you experience heaviness or dullness in the pelvic area?  yes  no
If yes, how much does it bother you?  1  2  3  4

3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?  yes  no
If yes, how much does it bother you?  1  2  3  4

4. Do you have to push on the vagina or rectum to complete a bowel movement?  yes  no
If yes, how much does it bother you?  1  2  3  4

5. Do you experience a feeling of incomplete bladder emptying?  yes  no
If yes, how much does it bother you?  1  2  3  4

6. Do you have to push up on a bulge in the vaginal area to start/complete urination?  yes  no
If yes, how much does it bother you?  1  2  3  4

7. Do you feel you need to strain too hard to have a bowel movement?  yes  no
If yes, how much does it bother you?  1  2  3  4

8. At the end of a bowel movement, do you feel you have not completely emptied your bowels?  yes  no
If yes, how much does it bother you?  1  2  3  4

9. If your stool is well formed, do you lose stool beyond your control?  yes  no
If yes, how much does it bother you?  1  2  3  4



**PATIENT  
QUESTIONNAIRE**

**KEY:**

- 1 - Not at All
- 2 - Somewhat
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- 4 - Quite a Bit

10. If your stool is loose or liquid, do you lose stool beyond your control?  yes  no  
**If yes,** how much does it bother you?  1  2  3  4
11. Do you lose gas from the rectum beyond your control?  yes  no  
**If yes,** how much does it bother you?  1  2  3  4
12. Do you have pain when you pass your stool?  yes  no  
**If yes,** how much does it bother you?  1  2  3  4
13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?  yes  no  
**If yes,** how much does it bother you?  1  2  3  4
14. Does a part of your bowel ever pass through your rectum and bulge outside, during, or after a bowel movement?  yes  no  
**If yes,** how much does it bother you?  1  2  3  4
15. Do you usually experience frequent urination?  yes  no  
**If yes,** how much does it bother you?  1  2  3  4
16. Do you experience urine leakage associated with a strong sensation of needing to go to the bathroom?  yes  no  
**If yes,** how much does it bother you?  1  2  3  4
17. Do you experience urine leakage related to coughing, sneezing, or laughing?  yes  no  
**If yes,** how much does it bother you?  1  2  3  4
18. Do you experience small amounts of urine leakage (that is drops)?  yes  no  
**If yes,** how much does it bother you?  1  2  3  4
19. Do you experience difficulty emptying your bladder?  yes  no  
**If yes,** how much does it bother you?  1  2  3  4
20. Do you experience pain or discomfort in the lower abdomen or genital region?  yes  no  
**If yes,** how much does it bother you?  1  2  3  4



**QUALITY OF LIFE  
ASSESSMENT**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Some women find that bladder, bowel or vaginal symptoms affect their activities, relationships, and feelings. Place an **X** in the response that best describes *how much* your activities, relationships or feelings have been affected **by your bladder, bowel or vaginal symptoms over the past 3 months.**

How do symptoms or conditions related to the following usually affect your...

**Ability to do household chores (cooking, housecleaning, laundry)?**

- | <u>Bladder or urine</u>              | <u>Bowel or rectum</u>               | <u>Vagina or pelvis</u>              |
|--------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Not at all  | <input type="checkbox"/> Not at all  | <input type="checkbox"/> Not at all  |
| <input type="checkbox"/> Somewhat    | <input type="checkbox"/> Somewhat    | <input type="checkbox"/> Somewhat    |
| <input type="checkbox"/> Moderately  | <input type="checkbox"/> Moderately  | <input type="checkbox"/> Moderately  |
| <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Quite a bit |

**Ability to do physical activities such as walking, swimming, or other exercise?**

- | <u>Bladder or urine</u>              | <u>Bowel or rectum</u>               | <u>Vagina or pelvis</u>              |
|--------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Not at all  | <input type="checkbox"/> Not at all  | <input type="checkbox"/> Not at all  |
| <input type="checkbox"/> Somewhat    | <input type="checkbox"/> Somewhat    | <input type="checkbox"/> Somewhat    |
| <input type="checkbox"/> Moderately  | <input type="checkbox"/> Moderately  | <input type="checkbox"/> Moderately  |
| <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Quite a bit |

**Entertainment activities such as going to a movie or concert?**

- | <u>Bladder or urine</u>              | <u>Bowel or rectum</u>               | <u>Vagina or pelvis</u>              |
|--------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Not at all  | <input type="checkbox"/> Not at all  | <input type="checkbox"/> Not at all  |
| <input type="checkbox"/> Somewhat    | <input type="checkbox"/> Somewhat    | <input type="checkbox"/> Somewhat    |
| <input type="checkbox"/> Moderately  | <input type="checkbox"/> Moderately  | <input type="checkbox"/> Moderately  |
| <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Quite a bit |

**Ability to travel by car or bus for a distance greater than 30 minutes away from home?**

- | <u>Bladder or urine</u>              | <u>Bowel or rectum</u>               | <u>Vagina or pelvis</u>              |
|--------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Not at all  | <input type="checkbox"/> Not at all  | <input type="checkbox"/> Not at all  |
| <input type="checkbox"/> Somewhat    | <input type="checkbox"/> Somewhat    | <input type="checkbox"/> Somewhat    |
| <input type="checkbox"/> Moderately  | <input type="checkbox"/> Moderately  | <input type="checkbox"/> Moderately  |
| <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Quite a bit |

**Participating in social activities outside your home?**

- | <u>Bladder or urine</u>              | <u>Bowel or rectum</u>               | <u>Vagina or pelvis</u>              |
|--------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Not at all  | <input type="checkbox"/> Not at all  | <input type="checkbox"/> Not at all  |
| <input type="checkbox"/> Somewhat    | <input type="checkbox"/> Somewhat    | <input type="checkbox"/> Somewhat    |
| <input type="checkbox"/> Moderately  | <input type="checkbox"/> Moderately  | <input type="checkbox"/> Moderately  |
| <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Quite a bit |



**QUALITY OF LIFE  
ASSESSMENT**

**Emotional Health (nervousness, depression, etc.)?**

Bladder or urine

- Not at all
- Somewhat
- Moderately
- Quite a bit

Bowel or rectum

- Not at all
- Somewhat
- Moderately
- Quite a bit

Vagina or pelvis

- Not at all
- Somewhat
- Moderately
- Quite a bit

**Feelings of frustration?**

Bladder or urine

- Not at all
- Somewhat
- Moderately
- Quite a bit

Bowel or rectum

- Not at all
- Somewhat
- Moderately
- Quite a bit

Vagina or pelvis

- Not at all
- Somewhat
- Moderately
- Quite a bit



**DAILY BLADDER DIARY**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

This diary will help you and your health care team understand your bladder function. It is a 24-hour record of your intake and output, as well as leakage episodes. The "sample" line below will show you how to use the diary.

Time	DRINKS		URINE		ACCIDENTS			Do you feel a strong urge to go? (circle one)	What were you doing at the time?
	What kind?	How much?	How many times did you "pee" during the hour?	How much? Use measuring cup (ml's or oz's)	How much? (check one)				
					small	med	large		
<b>Sample</b>	<b>coffee</b>	<b>2 cups</b>	<b>2</b>	<b>2 oz or 2 ml</b>	<input checked="" type="checkbox"/>			<b>Yes / No</b>	<b>Running</b>
6-7 AM								Yes / No	
7-8 AM								Yes / No	
8-9 AM								Yes / No	
9-10 AM								Yes / No	
10-11 AM								Yes / No	
11-12 noon								Yes / No	
12-1 PM								Yes / No	
1-2 PM								Yes / No	
2-3 PM								Yes / No	
3-4 PM								Yes / No	
4-5 PM								Yes / No	
5-6 PM								Yes / No	
6-7 PM								Yes / No	
7-8 PM								Yes / No	
8-9 PM								Yes / No	
9-10 PM								Yes / No	
10-11 PM								Yes / No	
11-12 mid								Yes / No	
12-1 AM								Yes / No	
1-2 AM								Yes / No	
2-3 AM								Yes / No	
3-4 AM								Yes / No	
4-5 AM								Yes / No	
5-6 AM								Yes / No	

