

## Atlantic Health System Division of Urogynecology & Reconstructive Pelvic Surgery

\_\_\_\_/\_\_\_\_/\_\_\_\_  
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? (____pks/day)    Y            N	Do you drink alcohol? (____drks/day) Y            N
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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 grey box below - 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**.

1) Do you experience pressure in the lower abdomen?

**If yes**, how much does it bother you?

**Key**

1 – Not At All

2 – Somewhat

3 – Moderately

4 – Quite A Bit

\_\_\_\_ NO    YES  
\_\_1\_\_ 2\_\_ 3\_\_ 4\_\_

2) Do you experience heaviness or dullness in the pelvic area?

**If yes**, how much does it bother you?

\_\_\_\_ NO    YES  
\_\_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?

**If yes**, how much does it bother you?

\_\_\_\_ NO    YES  
\_\_1\_\_ 2\_\_ 3\_\_ 4\_\_

4) Do you have to push on the vagina or rectum to complete a bowel movement?

**If yes**, how much does it bother you?

\_\_\_\_ NO    YES  
\_\_1\_\_ 2\_\_ 3\_\_ 4\_\_

5) Do you experience a feeling of incomplete bladder emptying?

**If yes**, how much does it bother you?

\_\_\_\_ NO    YES  
\_\_1\_\_ 2\_\_ 3\_\_ 4\_\_

6) Do you have to push up on a bulge in the vaginal area to start/complete urination?

**If yes**, how much does it bother you?

\_\_\_\_ NO    YES  
\_\_1\_\_ 2\_\_ 3\_\_ 4\_\_

7) Do you feel you need to strain too hard to have a bowel movement?

**If yes**, how much does it bother you?

\_\_\_\_ NO    YES  
\_\_1\_\_ 2\_\_ 3\_\_ 4\_\_

8) At the end of a bowel movement, do you feel you have not completely emptied your bowels?

**If yes**, how much does it bother you?

\_\_\_\_ NO    YES  
\_\_1\_\_ 2\_\_ 3\_\_ 4\_\_

### Your Daily Bladder Diary

Your name: \_\_\_\_\_

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.

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

The "sample" line (below) will show you how to use the diary.

Time	Drinks		Urine		ACCIDENTS			Did you feel a strong urge to go?		What were you doing at the time?
					Accidental Leaks					
					How much? (check one)					
	What kind?	How much?	How many times did you "pee" during the hour?	How much? Use the measuring cup (ml's or oz's)	How much? (check one)				Circle one	Sneezing, exercising, havng sex, lifting, etc.
Sample	<i>Coffee</i>	<i>2 cups</i>	<i>2</i>	<i>2 oz or 2 ml</i>	<input checked="" type="radio"/> sm	<input type="radio"/> med	<input type="radio"/> lg	<input type="radio"/> Yes	<input type="radio"/> No	<i>Running</i>
6-7 am								<input type="radio"/> Yes	<input type="radio"/> No	
7-8 am								<input type="radio"/> Yes	<input type="radio"/> No	
8-9 am								<input type="radio"/> Yes	<input type="radio"/> No	
9-10 am								<input type="radio"/> Yes	<input type="radio"/> No	
10-11 am								<input type="radio"/> Yes	<input type="radio"/> No	
11-12 noon								<input type="radio"/> Yes	<input type="radio"/> No	
12-1 pm								<input type="radio"/> Yes	<input type="radio"/> No	
1-2 pm								<input type="radio"/> Yes	<input type="radio"/> No	
2-3 pm								<input type="radio"/> Yes	<input type="radio"/> No	
3-4 pm								<input type="radio"/> Yes	<input type="radio"/> No	
4-5 pm								<input type="radio"/> Yes	<input type="radio"/> No	
5-6 pm								<input type="radio"/> Yes	<input type="radio"/> No	
6-7 pm								<input type="radio"/> Yes	<input type="radio"/> No	
7-8 pm								<input type="radio"/> Yes	<input type="radio"/> No	
8-9 pm								<input type="radio"/> Yes	<input type="radio"/> No	
9-10 pm								<input type="radio"/> Yes	<input type="radio"/> No	
10-11 pm								<input type="radio"/> Yes	<input type="radio"/> No	
11-12 mid								<input type="radio"/> Yes	<input type="radio"/> No	
12-1 am								<input type="radio"/> Yes	<input type="radio"/> No	
1-2 am								<input type="radio"/> Yes	<input type="radio"/> No	
2-3 am								<input type="radio"/> Yes	<input type="radio"/> No	
3-4 am								<input type="radio"/> Yes	<input type="radio"/> No	
4-5 am								<input type="radio"/> Yes	<input type="radio"/> No	
5-6 am								<input type="radio"/> Yes	<input type="radio"/> No	



PATIENT INFORMATION SHEET

**PATIENT INFORMATION:**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE # \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

**PRIMARY INSURANCE:**

POLICY HOLDER

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ EMPLOYER PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

INSURANCE NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

INSURANCE ID#: \_\_\_\_\_ GROUP #: \_\_\_\_\_

**SECONDARY INSURANCE:**

POLICY HOLDER

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ EMPLOYER PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

INSURANCE NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

INSURANCE ID#: \_\_\_\_\_ GROUP #: \_\_\_\_\_

MEDICAL PROVIDER INFORMATION SHEET

NAME: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

FAX NUMBER: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

FAX NUMBER: \_\_\_\_\_

**Key**

1. Not at all
2. Somewhat
3. Moderately
4. Quite a bit

- 9) If your stool is well formed, do you lose stool beyond your control?  
**If yes**, how much does it bother you? \_\_\_ NO \_\_\_ YES  
 \_\_\_1\_\_\_2\_\_\_3\_\_\_4
- 10) If your stool is loose or liquid, do you lose stool beyond your control?  
**If yes**, how much does it bother you? \_\_\_ NO \_\_\_ YES  
 \_\_\_1\_\_\_2\_\_\_3\_\_\_4
- 11) Do you lose gas from the rectum beyond your control?  
**If yes**, how much does it bother you? \_\_\_ NO \_\_\_ YES  
 \_\_\_1\_\_\_2\_\_\_3\_\_\_4
- 12) Do you have pain when you pass your stool?  
**If yes**, how much does it bother you? \_\_\_ NO \_\_\_ YES  
 \_\_\_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?  
**If yes**, how much does it bother you? \_\_\_ NO \_\_\_ YES  
 \_\_\_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?  
**If yes**, how much does it bother you? \_\_\_ NO \_\_\_ YES  
 \_\_\_1\_\_\_2\_\_\_3\_\_\_4
- 15) Do you usually experience frequent urination?  
**If yes**, how much does it bother you? \_\_\_ NO \_\_\_ YES  
 \_\_\_1\_\_\_2\_\_\_3\_\_\_4
- 16) Do you experience urine leakage associated with a strong sensation of needing to go to the bathroom?  
**If yes**, how much does it bother you? \_\_\_ NO \_\_\_ YES  
 \_\_\_1\_\_\_2\_\_\_3\_\_\_4
- 17) Do you experience urine leakage related to coughing, sneezing, or laughing?  
**If yes**, how much does it bother you? \_\_\_ NO \_\_\_ YES  
 \_\_\_1\_\_\_2\_\_\_3\_\_\_4
- 18) Do you experience small amounts of urine leakage (that is drops)?  
**If yes**, how much does it bother you? \_\_\_ NO \_\_\_ YES  
 \_\_\_1\_\_\_2\_\_\_3\_\_\_4
- 19) Do you experience difficulty emptying your bladder?  
**If yes**, how much does it bother you? \_\_\_ NO \_\_\_ YES  
 \_\_\_1\_\_\_2\_\_\_3\_\_\_4
- 20) Do you experience pain or discomfort in the lower abdomen or genital region?  
**If yes**, how much does it bother you? \_\_\_ NO \_\_\_ YES  
 \_\_\_1\_\_\_2\_\_\_3\_\_\_4

## Atlantic Health System Division of Urogynecology and Reconstructive Surgery

### Quality of Life Assessment

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)?*

Bladder or urine	Bowel or rectum	Vagina or Pelvis
<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?*

Bladder or urine	Bowel or rectum	Vagina or Pelvis
<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?*

Bladder or urine	Bowel or rectum	Vagina or Pelvis
<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?*

Bladder or urine	Bowel or rectum	Vagina or Pelvis
<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?*

Bladder or urine	Bowel or rectum	Vagina or Pelvis
<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

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

Bladder or urine	Bowel or rectum	Vagina or Pelvis
<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

#### *Feelings of frustration?*

Bladder or urine	Bowel or rectum	Vagina or Pelvis
<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