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

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**.

Key
1 – Not At All
2 – Somewhat
3 – Moderately
4 – Quite A Bit

1) Do you experience pressure in the lower abdomen? ____NO ___ YES
If yes, how much does it bother you? ___1 ___2 ___3 ___4

2) Do you experience heaviness or dullness in the pelvic area? ____NO ___ YES
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?
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? ____NO ___ YES
If yes, how much does it bother you? ___1 ___2 ___3 ___4

5) Do you experience a feeling of incomplete bladder emptying? ____NO ___YES
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? ____NO ___YES
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? ____NO ___YES
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? ____NO ___YES
If yes, how much does it bother you? ___1 ___2 ___3 ___4

Your Daily Bladder Diary

Your 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 Accidental Leaks How much? (check one)			Did you feel a strong urge to go?		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)	sm	med	lg	Circle one		Sneezing, exercising, havng sex, lifting, etc.
Sample	*Coffee*	*2 cups*	*2*	2 oz or 2 ml	Ö			Yes	No	*Running*
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	

Morristown Memorial Hospital
ATLANTIC HEALTH

OUTPATIENT /MULTIPLE VISITS
MEDICATION RRECONCILIATION FORM

Name:	Allergic To: /Describe Reaction:
Date of Birth:	Pharmacy Phone #:

Information Source: Patient/Family Rx bottles List of Medication MD/MD Office Pharmacy

Date started	Medication	Dose	Route	How Often	Reason for Taking	Discontinued Date

The medication list has been reviewed and revised as necessary.
Copy to patient / Primary care provider if changes made

Date	Int	Date	Int	Date	Int	Date	Int	Date	Int	Date	Int	Date	Int	Date	Int

PATIENT INFORMATION SHEET

PATIENT INFORMATION:

LAST NAME: ________________________ FIRST NAME:_______________ DATE OF BIRTH:_____________

ADDRESS:_________________________ CITY:____________ STATE:___________ ZIP:_______________

HOME PHONE: CELL PHONE #

E-MAIL ADDRESS: ____

EMPLOYER:___________________________ OCCUPATION:_____________ WORK PHONE:______________

SOCIAL SECURITY #:

PRIMARY LANGUAGE:_____________ ETHNIC ORIGIN:___________________

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:_______________

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? ____NO ___YES
If yes, how much does it bother you? ___1 ___2 ___3 ___4

10) If your stool is loose or liquid, do you lose stool beyond your control? ____NO ___YES
If yes, how much does it bother you? ___1 ___2 ___3 ___4

11) Do you lose gas from the rectum beyond your control? ____NO ___YES
If yes, how much does it bother you? ___1 ___2 ___3 ___4

12) Do you have pain when you pass your stool? ____NO ___YES
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? ____NO ___YES
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? ____NO ___YES
If yes, how much does it bother you? ___1 ___2 ___3 ___4

15) Do you usually experience frequent urination? ____NO ___YES
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? ____NO ___YES
If yes, how much does it bother you? ___1 ___2 ___3 ___4

17) Do you experience urine leakage related to coughing, sneezing, or laughing? ____NO ___YES
If yes, how much does it bother you? ___1 ___2 ___3 ___4

18) Do you experience small amounts of urine leakage (that is drops)? ____NO ___YES
If yes, how much does it bother you? ___1 ___2 ___3 ___4

19) Do you experience difficulty emptying your bladder? ____NO ___YES
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? ____NO ___YES
If yes, how much does it bother you? ___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**
___ Not at all	___ Not at all	____ Not at all
___ Somewhat	___ Somewhat	____ Somewhat
___ Moderately	___ Moderately	____ Moderately
___ Quite a bit	___ Quite a bit	____ Quite a bit

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

Bladder or urine	**Bowel or rectum**	**Vagina or Pelvis**
___ Not at all	___ Not at all	____ Not at all
___ Somewhat	___ Somewhat	____ Somewhat
___ Moderately	___ Moderately	____ Moderately
___ Quite a bit	___ Quite a bit	____ Quite a bit

Entertainment activities such as going to a movie or concert?

Bladder or urine	**Bowel or rectum**	**Vagina or Pelvis**
___ Not at all	___ Not at all	____ Not at all
___ Somewhat	___ Somewhat	____ Somewhat
___ Moderately	___ Moderately	____ Moderately
___ Quite a bit	___ Quite a bit	____ 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**
___ Not at all	___ Not at all	____ Not at all
___ Somewhat	___ Somewhat	____ Somewhat
___ Moderately	___ Moderately	____ Moderately
___ Quite a bit	___ Quite a bit	____ Quite a bit

Participating in social activities outside your home?

Bladder or urine	**Bowel or rectum**	**Vagina or Pelvis**
___ Not at all	___ Not at all	____ Not at all
___ Somewhat	___ Somewhat	____ Somewhat
___ Moderately	___ Moderately	____ Moderately
___ Quite a bit	___ Quite a bit	____ Quite a bit

Emotional Health (nervousness, depression,etc.)?

Bladder or urine	**Bowel or rectum**	**Vagina or Pelvis**
___ Not at all	___ Not at all	____ Not at all
___ Somewhat	___ Somewhat	____ Somewhat
___ Moderately	___ Moderately	____ Moderately
___ Quite a bit	___ Quite a bit	____ Quite a bit

Feelings of frustration?

Bladder or urine	**Bowel or rectum**	**Vagina or Pelvis**
___ Not at all	___ Not at all	____ Not at all
___ Somewhat	___ Somewhat	____ Somewhat
___ Moderately	___ Moderately	____ Moderately
___ Quite a bit	___ Quite a bit	____ Quite a bit