Penn Medicine
Princeton Health

Greetings,

On behalf of all the providers and the entire staff of our practice, thank you for choosing Penn Medicine Princeton Urogynecology. We are pleased to welcome you as a new patient in our practice and appreciate the opportunity to provide you with excellent healthcare.

Please arrive 15 minutes prior to your scheduled time so that we can complete your registration. **We make every effort to stay on schedule and avoid unnecessary waiting. If you are late, we may need to reschedule your appointment.**

Please make sure to arrive with a comfortably full bladder for a proper pelvic floor evaluation (regardless of your symptoms or diagnosis).

We value your time spent in our office and would like to focus that time on your exam and treatment recommendations. In order to do that, **we require that you complete extensive medical history forms and have them returned to our office at least 3 days prior to your scheduled appointment**. This also allows you to complete them at your own pace and to ensure that the information is accurate and complete. These forms ultimately will help to focus our time spent together and to better serve you and address your concerns appropriately. ***Please be aware that your appointment is not considered secured/confirmed until we receive your new-patient paperwork.**

YOUR PAPERWORK MUST BE RETURNED AT LEAST 3 BUSINESS DAYS BEFORE YOUR APPOINTMENT, IN ORDER FOR YOU TO BE SEEN:

- You can mail the paperwork back to us but you must allow for appropriate time for them to reach us 3 days before your appointment. Note: Mailing back the forms requires 87 cents postage.
- You can fax the forms to 609-924-5006.
- You can email the forms to: PMPH-Urogynecology@pennmedicine.upennedu
- You can also drop them off.

If you have had any recent medical testing or prior treatment/surgery for your condition, please contact those facilities/offices and ask that the results be sent to our office so that they are available for review at the time of your office evaluation. Our fax # is (609) 924-5006.

Please bring your insurance card(s), co-pay, a photo ID and any insurance referral if required by your insurance plan. Failure to have an appropriate insurance referral at the time of your visit can result in you being responsible for the entire cost of your visit.

Wearing a mask is now optional in our practice. If you would like your clinician to wear a mask, please let us know upon check-in. If you are having any respiratory symptoms, please wear a mask out of courtesy.

No Show Policy

When you schedule an appointment with one of our providers, that time is reserved exclusively for you. We do understand that on occasion unforeseen circumstances do arise and the need to cancel your scheduled appointment may be necessary. If you know that you will be unable to keep your appointment, we ask you to show consideration by calling our office 48 hours in advance. Providing our office with adequate notice will allow us to offer that appointment time to another patient who is waiting to see our providers.

Thank you and we look forward to welcoming you to our practice.

Sincerely,

Catherine Ayres

Catherine Ayres, Practice Manager

Penn Medicine Princeton Urogynecology
10 Forrestal Road South, Suite 205, Princeton, NJ 08540
2346 Route 33, Suite E-107, Robbinsville, NJ 08691
350 Forsgate Drive, Suite 103, Monroe, NJ 08831
P: (609) 924-2230 • F: (609) 924-5006
www.PrincetonUrogyn.com

PENN MEDICINE **Date:** _____

PRINCETON UROGYNECOLOGY

Name:	Date of Birth:	Age:
Address:	City, State:	Zip Code:

Home Phone:	Work Phone:	Cell Phone:
Social Security #:	Email Address:	Marital Status: S M W SEP D

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name:	Relationship to Patient:	
Home Phone:	Work Phone:	Cell Phone:

PHYSICIAN AND PHARMACY INFORMATION:

Referring Physician:	Address:	Office Phone:
Primary Care Physician:	Address:	Office Phone:
GYN Physician:	Address:	Office Phone:
Local Pharmacy:	Address:	Phone:
Mail Order Pharmacy:	Address:	Phone:

PATIENT EMPLOYER INFORMATION:	SPOUSE'S INFORMATION:
Employer's Name:	Spouse's Name:
Patient's Occupation:	Spouse's Employer:

PRIMARY INSURANCE INFORMATION:

Name of Primary Insurance:	Insurance ID #:	
Subscriber's Name:	Group #:	Co-Pay:
Subscriber's Date of Birth:	Prescription Plan Information:	

SECONDARY INSURANCE INFORMATION:

Name of Secondary Insurance:	Insurance ID #:	
Subscriber's Name:	Group #:	Co-Pay:
Subscriber's Date of Birth:	Prescription Plan Information:	

Penn Medicine
Princeton Health

PRINCETON UROGYNECOLOGY

New Patient Information Form

PLEASE DOWNLOAD AND COMPLETE THIS FORM (PDF OR PRINT) AND
EMAIL TO PMPH-Urogynecology@pennmedicine.upenn.edu OR FAX TO (609) 924-5006

(Forms must be returned at least 3 days prior to your scheduled appointment, in order to keep your appointment as scheduled.)

Patient Name: _____ DOB: _____

Preferred Name (if different): _____ Age: _____

Please briefly summarize the reason for your visit.

How long have you had this issue/symptoms?

Have you sought healthcare elsewhere for this issue? ☐ NO ☐ YES

If so, who did you see and what treatments (including medications and surgery) and/or diagnostic testing have you undergone?

ARE YOU ALLERGIC TO:		**Reaction**
Latex?	☐ No ☐ Yes	
Plastic?	☐ No ☐ Yes	
Iodine?	☐ No ☐ Yes	
Radiology contrast/dye?	☐ No ☐ Yes	
Adhesive? Tape/bandaids?	☐ No ☐ Yes	

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS (Prescription or over-the-counter)?

☐ **No** ☐ **Yes (Please list below)**

List your medication allergies	**Reaction**

Name: _____ DOB: _____

CURRENT MEDICATIONS: ☐ None

Please list your CURRENT medications including supplements	Dose	Times per day	Approx Start Date

MEDICAL HISTORY: Please mark with an X if you have/had any of the following medical conditions:

- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Anticoagulation Therapy
- ☐ Neurologic Disease
- ☐ Stomach Ulcer
- ☐ Hypothyroidism
- ☐ Cancer
  What Type: _____
- ☐ Uterine Fibroids
- ☐ Constipation
- ☐ Other Medical Problems: _____

- ☐ Heart attack
- ☐ Depression/Anxiety
- ☐ Blood clots (DVT/PE)
- ☐ Pelvic Radiation
- ☐ Back Injury
- ☐ Back Pain or Sciatica
- ☐ Kidney Disease
- ☐ Blood in Urine
- ☐ Dry Mouth or Dry Eyes
- ☐ Sleep Apnea

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Stroke
- ☐ Hypothyroid
- ☐ Glaucoma type: _____
- ☐ Botox Use _____
- ☐ Recurrent UTIs
- ☐ Jehovah's Witness
  Refuse Blood Products
- ☐ Insomnia

SURGICAL HISTORY – Please list ALL surgeries.

Date	Surgery	Comments

Please provide more details here if needed:

NOTE: If you have had a prior pelvic surgery, it would be beneficial to obtain the operative note(s) so that we can review them. Please contact your prior surgeon's office and have them fax the report(s) to (609) 924-5006.

Name: _____ DOB: _____

FAMILY HISTORY:

☐ No Family Medical History ☐ History Unknown/Adopted

	High BP	Diabetes	Heart Attack	Stroke	Kidney Disease	Breast Cancer	Bladder Cancer	Other Cancer	Bleeding Problems	Thyroid Disease	Asthma
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Daughter	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Son	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Please provide more details here if needed:

SOCIAL HISTORY:	
Tobacco Use:	☐ Never ☐ Current: Frequency: _____ ☐ Former: Quit date: _____ How many years have you been smoking or did you smoke? _____
Smokeless Tobacco:	☐ Never ☐ Current: _____ Frequency: _____ ☐ Former: Quit date: _____
Caffeine Intake:	☐ No ☐ Yes: Type, Amount, Frequency: _____
Alcohol Intake:	☐ Never ☐ Yes: Type, Amount, Frequency: _____ ☐ Not Currently
Race:	☐ Decline ☐ American Indian/Alaskan ☐ Asian Indian ☐ Black/African American ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Hawaiian ☐ Samoan ☐ Vietnamese ☐ White
Ethnicity:	☐ Decline ☐ Not Spanish/Hispanic/Latino ☐ Central/South American ☐ Cuban ☐ Mexican/Mexican-American/Chicano ☐ Other Spanish/Hispanic/Latino ☐ Puerto Rican

REVIEW OF SYSTEMS – Please check all that apply.

Constitutional	☐ Unusual fatigue	☐ Fever	☐ Weight Loss	☐ Loss of appetite
Eyes	☐ Double Vision	☐ Blurred vision	☐ Glasses/Contacts	☐ Dry eyes
Ears, Nose & Throat	☐ Hearing loss	☐ Hoarseness	☐ Ringing in ears	☐ Difficulty swallowing
Cardiac	☐ Chest pain	☐ Irregular heart beats	☐ Palpitations	☐ Difficulty breathing on exertion
Pulmonary	☐ Shortness of breath	☐ Chronic cough	☐ Wheezing	☐ Difficulty breathing when lying down
Gastrointestinal	☐ Nausea/vomiting	☐ Blood in stool	☐ Chronic diarrhea	☐ Constipation
Musculoskeletal	☐ Pain in joints	☐ Lower back pain	☐ Muscle Weakness	☐ Muscle spasm
Skin	☐ Unusual bruising	☐ Hair loss	☐ Unexplained rash	☐ Dry skin
Neurologic	☐ Seizures	☐ Frequent headaches	☐ Numbness	☐ Fainting
Psychiatric	☐ Depressed	☐ Difficulty sleeping	☐ Memory loss	☐ Anxiety
Endocrine	☐ Hot flashes	☐ Dry skin	☐ Heat/Cold sensitivity	☐ Hair loss
Blood Diseases	☐ Anemia	☐ Bleeding problems	☐ Swollen glands	☐ Hepatitis
Allergy	☐ Sinus problems	☐ Allergic reaction	☐ Seasonal allergies	☐ Conjunctivitis
Other	☐ Vaginal dryness	☐ _____	☐ _____	☐ _____

Name: _____ DOB: _____

OBSTETRIC AND GYNECOLOGIC HISTORY:

Date or age of last menstrual period: _____ Date of last Pap smear: _____ Result? _____

Date of last mammogram: _____ Result? _____

Have you ever had a sexually transmitted disease? ☐ No ☐ Yes: (what/when) _____

Number of Pregnancies: _____

Number of Vaginal deliveries: _____ Number of Cesarean births: _____ Number of Miscarriages/abortions: _____

If you have had a vaginal delivery:

- Please tell us the weight of your largest baby born vaginally: _____ pounds _____ ounces
- Please indicate if you have EVER had the following:
  ☐ Forcepts delivery ☐ Vacuum delivery ☐ Severe tear after delivery ☐ Episiotomy
  ☐ Other complications or prolonged labor: _____

CHECK the category below to indicate when you went through menopause:		
☐	Have not gone through menopause	Are you using any form of contraception? ☐ No ☐ Yes – Type(s): _____ Have you completed your family? ☐ No ☐ Yes ☐ Unsure
☐	Going through menopause now	☐ Yes ☐ Unsure
☐	I went through menopause at age _____.	After menopause, did you use hormone replacement therapy? ☐ Never ☐ Past ☐ Current After menopause, did you use vaginal hormone therapy? ☐ Never ☐ Past ☐ Current

Are you sexually active at the present time: ☐ No ☐ No, but would like to be ☐ Yes

(If no, skip questions 1-13 below.)

The following are a list of questions about you and your partner's sex life. All information is strictly confidential. Your answers will be used only to help your provider understand how your condition is affecting you and what is important to 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.
   ☐ Daily ☐ Weekly ☐ Monthly ☐ Less than once a month ☐ 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
13. Does your prolapse or incontinence decrease your partner's desire to have sexual relations?
    ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

Name: _____ DOB: _____

SECTION 1: URINARY SYMPTOMS:

How often do you typically urinate during the day? Every _____ hours, _____ # of times per day.
How often do you urinate during the night after going to bed? _____ # of times per night.
Do you TYPICALLY have pain or burning when you urinate? ☐ No ☐ Yes
Do you TYPICALLY have pain when your bladder if full? ☐ No ☐ Yes
If so, does the pain resolve when you empty? ☐ No ☐ Yes
Do you leak urine? ☐ No (skip to Section 2) ☐ Yes
TYPICALLY, how many times do you leak urine during the daytime?
☐ Never ☐ _____ times per **(check one)** ☐ day ☐ week ☐ month
In the last month, how many times have you wet the bed at night?
☐ Never ☐ _____ times per **(check one)** ☐ day ☐ week ☐ month
Do you wear protection for urine loss? ☐ No **(skip to Section 2)** ☐ Yes

Use the following table to indicate how many of the following pads you use during the day and night.

	Tissue	Mini-pad/liner	Regular pad	Heavy pad or diaper
Daytime				
Night Time				

When you change your pads, are they: ☐ Dry ☐ Have a few drops ☐ Wet ☐ Soaked

SECTION 2: BOWEL SYMPTOMS:

How many movements do you typically have each week? _____
Do you have trouble with bowel movements? Diarrhea? ☐ No ☐ Yes Constipation? ☐ No ☐ Yes
Do you have accidental bowel leakage? ☐ No **(skip to Section 3)** ☐ Yes
In a TYPICAL month, how often do you have accidental bowel leakage? _____ # times per month
Do you use pads or devices for bowel leakage? ☐ No ☐ Yes, # _____ per day

SECTION 3: TREATMENT HISTORY:

Have you had prior treatment for PELVIC PROLAPSE, URINARY or BOWEL problems?
☐ No ☐ Yes – use the table below to indicate which treatments you have tried.

Treatment	**Tried**
Pelvic muscle exercises (Kegel or pelvic floor physical therapy)	☐ No ☐ Yes – Did it help? _____
Pessary or vaginal device	☐ No ☐ Yes – Did it help? _____
Medications (Check the ones that you have tried and list the reason for stopping (side effects or did not help):	
☐ Darifenacin (Enablex) _____	☐ Trospium (Sanctura) _____
☐ Tolterodine (Detrol) _____	☐ Nocdurna _____
☐ Solifenacin (Vesicare) _____	☐ Oxytrol patch _____
☐ Mirabegron (Myrbetriq) _____	☐ Oxybutynin (Ditropan, Gelnique) _____
☐ Fesoterodine (Toviaz) _____	☐ Botox _____
☐ Vibegron (Gemtesa) _____	☐ _____

NOTES:

Name: _____ DOB: _____

Pelvic Floor Distress Inventory – 20

Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, how much they bother you. Answer these by putting an X in the appropriate box or boxes. While answering these questions, please consider your symptoms over the last 3 months.

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)			**If YES, how much does it bother you?**			
Do you _____?	**NO**	**YES**	**1 Not at all**	**2 Some what**	**3 Mod-erately**	**4 Quite a bit**
1. Usually experience pressure in the lower abdomen?	☐	☐	☐	☐	☐	☐
2. Usually experience heaviness or dullness in the pelvic area?	☐	☐	☐	☐	☐	☐
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	☐	☐	☐	☐	☐	☐
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	☐	☐	☐	☐	☐	☐
5. Usually experience a feeling of incomplete bladder emptying?	☐	☐	☐	☐	☐	☐
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	☐	☐	☐	☐	☐	☐
Colorectal-Anal Distress Inventory 8 (CRADI-8):						
7. Feel you need to strain too hard to have a bowel movement?	☐	☐	☐	☐	☐	☐
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	☐	☐	☐	☐	☐	☐
9. Usually lose stool beyond your control if your stool is well-formed?	☐	☐	☐	☐	☐	☐
10. Usually lose stool beyond your control if your stool is loose?	☐	☐	☐	☐	☐	☐
11. Usually lose gas from the rectum beyond your control?	☐	☐	☐	☐	☐	☐
12. Usually have pain when you pass your stool?	☐	☐	☐	☐	☐	☐
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	☐	☐	☐	☐	☐	☐
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	☐	☐	☐	☐	☐	☐
Urinary Distress Inventory 6 (UDI-6):						
15. Usually experience frequent urination?	☐	☐	☐	☐	☐	☐
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	☐	☐	☐	☐	☐	☐
17. Usually experience urine leakage related to coughing, sneezing, or laughing?	☐	☐	☐	☐	☐	☐
18. Usually experience small amounts of urine leakage (that is, drops)?	☐	☐	☐	☐	☐	☐
19. Usually experience difficulty emptying your bladder?	☐	☐	☐	☐	☐	☐
20. Usually experience pain or discomfort in the lower abdomen or genital region?	☐	☐	☐	☐	☐	☐

Name: _____ DOB: _____

PART I: URINARY STRESS SYMPTOMS (MESA)	0 Never	1 Rarely	2 Some-times	3 Often
(Would you say.....)				
1. Does coughing gently cause you to lose urine?	☐	☐	☐	☐
2. Does coughing hard cause you to lose urine?	☐	☐	☐	☐
3. Does sneezing cause you to lose urine?	☐	☐	☐	☐
4. Does lifting things cause you to lose urine?	☐	☐	☐	☐
5. Does bending cause you to lose urine?	☐	☐	☐	☐
6. Does laughing cause you to lose urine?	☐	☐	☐	☐
7. Does walking briskly or jogging cause you to lose urine?	☐	☐	☐	☐
8. Does straining, if you are constipated, cause you to lose urine?	☐	☐	☐	☐
9. Does getting up from a sitting to a standing position cause you to lose urine?	☐	☐	☐	☐

PART II: URINARY URGE SYMPTOMS (MESA)	0 Never	1 Rarely	2 Some-times	3 Often
1. Some women receive very little warning and suddenly find that they are losing, or are about to lose urine beyond their control. How often does this happen to you?	☐	☐	☐	☐
2. If you cannot find a toilet or find that the toilet is occupied, and you have an urge to urinate, how often do you end up losing urine or wetting yourself.	☐	☐	☐	☐
3. Do you lose urine when you suddenly have the feeling that your bladder is very full?	☐	☐	☐	☐
4. Does washing your hands cause you to lose urine?	☐	☐	☐	☐
5. Does cold weather cause you to lose urine?	☐	☐	☐	☐
6. Do drinking cold beverages cause you to lose urine?	☐	☐	☐	☐

PGI-S	1 Normal	2 Mild	3 Moder-ate	4 Severe
Check the number that best describe how your urinary tract condition is Now.	☐	☐	☐	☐

Name: _____ DOB: _____

BLADDER/VOIDING DIARY

PRIOR TO YOUR VISIT WITH US:

PLEASE COMPLETE THIS BLADDER DIARY IF YOU ARE SEEKING HELP FOR ANY OF THE FOLLOWING PROBLEMS.

- URINARY FREQUENCY
- URINARY URGENCY
- URINARY LEAKAGE (INCONTINENCE)
- WAKING UP AT NIGHT TO URINATE
- PELVC ORGAN PROLAPSE

This diary is a record of your fluid intake, voiding (urinating), and incontinence (leakage of urine).

INSTRUCTIONS:

1. Choose two 24-hour periods of time to keep this record. They do not have to be 2 days in succession. You will need to measure every void (urination) and the amount of all liquid you drink during those 24 hours.
2. Begin your record with the FIRST void when you arise from sleep (see the examples below).
3. Use a standard 1 or 2 cup plastic measuring device and record in ounces or milliliters.
4. After voiding, you may discard that urine after you measure it (no need to collect the urine).
5. Record any leakage of urine and whether this was a small (1), moderate (2), or severe (3) leakage episode. Indicate whether you had an urge to urinate at the time of leakage.

Example:

TIME	Amount Voided	LEAK AMOUNT 1 – small 2 – moderate 3 - severe	ACTIVITY DURING LEAK	URGE PRESENT? Yes or No	FLUID INTAKE Amount and Type
6:45 AM	500 mL		Just awakened		
7:00 AM					6 oz OJ
8:45 AM		2	Turned on water		16 oz coffee

Name: ______________________________ DOB: ________________

BLADDER/VOIDING DIARY

Date: ______________________________

TIME	Amount Voided	LEAK AMOUNT 1 – small 2 – moderate 3 – severe	ACTIVITY DURING LEAK	URGE PRESENT? Yes or No	FLUID INTAKE Amount And Type

Name: ______________________________ DOB: ______________

BLADDER/VOIDING DIARY

Date: ______________________________

TIME	Amount Voided	LEAK AMOUNT 1 – small 2 – moderate 3 – severe	ACTIVITY DURING LEAK	URGE PRESENT? Yes or No	FLUID INTAKE Amount And Type