Princeton
UROGYNECOLOGY

www.princetonurogyn.com

Heather van Raalte, MD
Nina Bhatia, MD
Andrea Barker, PA

Welcome to Princeton Urogynecology, a practice solely dedicated to the care of pelvic floor disorders affecting women. We specialize in the comprehensive evaluation and management of female pelvic health specializing in prolapse of the uterus, vagina, bladder, urethra and rectum, urinary incontinence (loss of bladder control) and fecal incontinence (loss of bowel control). We take pride in keeping ahead of the latest innovations to bring patients the most up-to-the minute therapies and minimally invasive procedures coupled with attention to personalized service

On your first visit, we will carefully review your medical history, perform a comprehensive pelvic exam, collect a urine sample for analysis and do a simple bladder function test called uroflowmetry. Our physicians will talk with you about their findings and, if necessary, will schedule an additional diagnostic test called urodynamics.

When we have pinpointed the cause of your problem, we will discuss your treatment options with you. Many problems can be corrected or controlled without surgery, although sometimes surgery is needed to repair defects of pelvic support.

During your care, you will also work with our certified nurse who will assist in working with you to coordinate follow-up visits and monitor your treatment plan. Our nurse has years of specialized experience in urogynecology and is readily available to help answer any questions you may have.

Throughout the process, we keep in close touch with your primary or referring physician, who is an important part of your treatment.

Because we value each patient's individual care, we ask that you complete the enclosed forms, questionnaires and bladder diary in order to ensure you receive the most comprehensive care at your visit.

tel 609.924.2230 • fax 609.924.5006
Forrestal Professional Park, Suite 205, 10 Forrestal Road, Princeton, NJ 08540

PRINCETON UROGYNECOLOGY

Our address is:
10 Forrestal Road South
Suite 205
Princeton, NJ 08540

phone: 609-924-2230
fax: 609-924-5006

Directions:

GPS WARNING: Because this extension of Forrestal Road is NEW, it may not appear on your GPS correctly. It may be easier to locate by GPS by entering the intersection of Scudder's Mill and Campus Roads. Turn onto Campus Road in the direction away from the hospital, the turn onto Forrestal Road South. ***The office building is not located in the hospital or in Forrestal Village.***

From North Route 1 (New Brunswick Direction):
Travel South on Route 1, Exit at the Scudder's Mill Road Exit (just before Princeton Hospital), Take the first Left at Campus Drive, take the first Left onto Forrestal Road South. The building, #10, is the first on your Right.

From South Route 1 (Hamilton/Trenton Direction):
Travel North on Route 1, Exit at the Scudder's Mill Road Exit (just after Princeton Hospital), Take the first Left at Campus Drive, take the first Left onto Forrestal Road South. The building, #10, is the first on your Right.

From West, PA-95:
Travel West on Route 95, Exit at Route 1 North (towards New Brunswick), Exit at the Scudder's Mill Road Exit (just after Princeton Hospital), Take the first Left at Campus Drive, take the first Left onto Forrestal Road South. The building, #10, is the first on your Right.

From East (Plainsboro/Monroe Direction):
Follow Dey Road to Scudder's Mill Road, Turn Right at Campus Drive (the opposite side of Scudder's Mill as the hospital), take the first Left onto Forrestal Road South. The building, #10, is the first on your Right.

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Name		Date of Birth month day year	Age
Address		City State	Zip
Home Phone	Work Phone	Cell Phone	
Social Security #		Marital Status: M S W D	
Emergency Information			
Emergency Contact Name		Relationship	
Emergency Contact Home Phone	Work Phone	Cell Phone	
Physician and Pharmacy Information			
Referring Physician	Address	Phone Number	
Primary Care Physician	Address	Phone Number	
Pharmacy Name	Address	Phone Number	
Patient Employer Information		**Spouse's Information**	
Patient's Employer		Spouse's Name	
Occupation		Spouse's Employer	
Primary Insurance Information			
Name of Primary Insurance		Insurance ID #	
Subscriber's Name		Group #	
Subscriber's Date of Birth		Co-Pay $	Prescription Plan: Yes No
Secondary Insurance Information			
Name of Secondary Insurance		Insurance ID #	
Subscriber's Name		Group #	
Subscriber's Date of Birth		Co-Pay $	Prescription Plan: Yes No

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CONSENT FOR TREATMENT: **The undersigned grants authorization to the physicians, associates, and staff at Princeton Urogynecology for such treatment and procedures that may be necessary for the patient herein named in accordance with the judgment of the physician. The undersigned acknowledges that no guarantees have been made as to the results of treatments or examinations in the office, or otherwise.**
I realize that I have the right to refuse any drugs, treatment, or procedures to the extent permitted by law.

AUTHORITY TO REVIEW AND RELEASE RECORDS AND INFORMATION: **The undersigned hereby authorizes and requests the physicians, associates, and staff at Princeton Urogynecology to furnish and release upon written request to all insurance companies or their representatives insuring the patient named, to Princeton Urogynecology and to any specific person herein named below, any and all information with respect to the patient herein named including, but not limited to, the case history, examination, prognosis, treatment medication, x-rays or surgery. Billing agencies which provide specialized services, routinely will receive information necessary for billing purposes. Medical records may also be used for educational or research purposes with the patient protected. Authorization is hereby given to physicians, associates, and staff at Princeton Urogynecology to release patient's name, age, sex, and nature of admission and general condition.**

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: **The undersigned understands and hereby releases physicians, associates, and staff at Princeton Urogynecology from any responsibility due to loss or damage of any valuables that the patient or the undersigned may keep in his possession in the office or hospital.**

PAYMENT GUARANTEE: **The undersigned hereby guarantees payment of all fees and charges incurred by patient for services that may not be covered under the insurance plan of the insured. In the event that the undersigned fails to make payment as provided herein or agree to alternative payment arrangements deemed satisfactory by Princeton Urogynecology, affirmative collection measures will be initiated. The undersigned agrees to pay all costs of collections, including fifteen (15%) percent of the unpaid balance as a reasonable attorney's fee in the event that such indebtedness is turned over to any attorney for collection.**

ASSIGNMENT OF BENEFITS: **I request payment of authorized benefits to Princeton Urogynecology for all services rendered. I authorize any holder of medical or other information about me to release to my insurance carrier and its agents, any information needed to determine these benefits or benefits for related services.**

The undersigned certifies that (s)he has read the forgoing, that it has been fully explained and that (s)he understands its contents, and hereby agrees to all terms and conditions set forth in the above paragraphs and acknowledges the receipt of a copy if requested.

_____ _____
Patient Signature **Date of Signature**

_____ _____
Signature of Patient Agent or Representative **Relationship to Patient**

_____
Witness Signature

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For All New Patients:

PLEASE BE ADVISED THAT YOUR NEW PATIENT VISIT MAY INCLUDE SOME DIAGNOSTIC TESTING. MANY INSURANCE COMPANIES WILL CLASSIFY THESE TESTS AS A "SURGERY" BUT THEY ARE ACTUALLY JUST A TEST DONE IN THE OFFICE.

IT IS YOUR RESPONSIBILITY TO KNOW IF YOU WILL OWE ANY DEDUCTIBLE, COINSURANCE AND OR COPAY.

WE HAVE INCLUDED THE PROCEDURE CODES OF SOME POSSIBLE TESTING THAT COULD BE COMPLETED SO YOU MAY CALL YOUR INSURANCE COMPANY.

UROFLOMETRY (51741): A special commode to measure amount of urine voided and speed of flow.

BLADDER SCAN (51798): An external ultrasound of the lower abdomen to measure amount of urine in the bladder.

CYSTOUROTHROSCOPY (52000): A camera device approximately the size of a catheter that is inserted into the bladder and a picture onto a TV screen to rule out any stones, tumors or cancer of the bladder.

I have read and understand the above information and will be responsible for any copays or monies due from any of these tests.

_____ _____

Patient Signature Date

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Princeton Urogynecology
HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)
PATIENT ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how Princeton Urogynecology may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. Please review our Notice thoroughly before signing this Acknowledgement Form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment and health care operations. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations.

The patient understands that:

- PHI may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has had the opportunity to review this Notice.
- The Practice reserves their right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their PHI, but the Practice does not have to agree to those restrictions.

I give permission for Princeton Urogynecology to:

_____Leave a message regarding an appointment at your designated phone number.
(Note: This is only a reminder of your appointment. No clinical information will be released).

_____Share medical information with:
Name_____
Relationship_____

Name _____
Relationship_____

I assume responsibility to inform Princeton Urogynecology of any changes in the above information.

Print Patient's Name	Date:
Signature	Relationship to Patient (if other than patient
Witness	

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Our Financial Policy

Thank you for choosing Princeton Urogynecology as your health care provider. Please take a moment to read our financial policy.

As a result of our excellent reputation we see many patients from outside the Princeton area. While we participate in many health plans, there are some in which we are non-participating. Please be aware that most health plans do include out-of-network benefits that will cover a significant portion of the services rendered. If we do not participate in your plan, we will be glad to review your financial resposibility.

Insurance Policy

Your insurance policy is a contract between you and your insurance company. Professional care is provided to you, our patient, and not to an insurance company. Thus, the insurance company is responsible to the patient, and the patient is responsible to the doctor. You are ultimately responsible for payment to our doctors for provided services.

We will gladly process your claim, but we request your estimated portion be paid in full at the time of service. If your insurance company has not paid your account in full within 60 days, you will have 30 days to arrange payment of the balance due.

If you are a member of a managed care plan in which we are a participating provider, please understand we require payment of co-pays and deductibles at time of service.

Referrals

If your health plan requires a referral, we cannot provide services to you without it. It is **YOUR RESPONSIBILITY** to contact your primary care physician and request a referral. Your primary care physician may be able to forward the referral to us electronically.

If we do not receive your referral one week prior to your appointment, we will remind you to contact your primary care physician.

IF WE HAVE NOT RECEIVED YOUR REFERRAL BY NOON THE DAY BEFORE YOUR APPOINTMENT, THE APPOINTMENT WILL BE RESCHEDULED.

OVER ⇨

tel 609.924.2230 • fax 609.924.5006
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Appointment Cancellation Policy
If you are unable to keep your appointment, kindly give us 24 hours notice. Your appointment time then can be made available to a patient on our wait list. If notice of cancellation is not received, you will be charged as follows:

New patient consult: $50

Established patient visit: $25

Medicare Authorization and Assignment
We do accept assignment of benefits, however, we are legally required to collect your deductible and 20% coinsurance at the time of service unless you have supplemental insurance.
I request that payment of authorized Medicare benefits be made on my behalf to the service provider for any services to me. I authorize any holder of medical information about me to release to the Health Care Financial Administration and its agents and information needed to determine these benefits or the benefits payable to related services. I hereby authorize payment directly to the service provider for the medical benefits, if any, otherwise payable to me under the terms of my private, group employer's coverage or Medigap insurance. I hereby authorize the service provider to release any medical information necessary to process my claim. I hereby authorize the photocopies of the form to be treated as originals.

Patient Signature_____ **Date**_____

Commercial Insurance Authorization and Assignment
I request that payment of authorized insurance benefits be made on my behalf to the service provider for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I hereby authorize payment directly to the service provider for the medical benefits, if any, otherwise payable to me under the terms of my private, group employer's coverage or Medigap insurance. I hereby authorize the service provider to release any medical information necessary to process my claim. I hereby authorize the photocopies of the forms be treated as originals.

Patient Signature_____**Date**_____

PLEASE SIGN BELOW ACKNOWLEDGING THAT YOU FULLY UNDERSTAND OUR FINANCIAL POLICY

Patient signature_____**Date**_____

We look forward to providing you with excellent care.
If you have any questions about our financial policy, Please contact us at 609-924-2230

MEDICAL HISTORY QUESTIONNAIRE

***** ALL NEW PATIENTS PLEASE COME TO YOUR VISIT WITH A FULL BLADDER *****

Name	Date of Birth	Age	Drug Allergies:	Reactions:
Please describe the reason for your visit (chief complaint)				

OBSTETRIC HISTORY

Number of Pregnancies:	Vaginal Deliveries:	Cesarean Deliveries:	Largest Baby Weight:
Forceps or Vaccum ☐ Yes ☐ No	Episiotomy ☐ Yes ☐ No	Laceration/Tear ☐ Yes ☐ No	
Degree/Details	Other Complications or Prolonged Labor		

GYNECOLOGIC HISTORY

Gynecologist Name:	Do you experience any of the following? (check ones you have)
Gynecologist Phone Number:	____ Bleeding between periods
Date of last menstrual period:	____ Heavy menstrual periods
Date of last PAP smear: Normal?	____ Pain with periods
Date of last mammogram: Normal?	____ Bleeding after intercourse
Have you ever had a sexually transmitted disease? If yes, when?	____ Pain with intercourse
Are you sexually active at the present time?	____ "Falling" of pelvic organs or prolapse
Are you using contraception? If yes, what type?	Are you presently taking, or have you taken in the past, hormone replacement therapy? If yes, medication and dose schedule, vaginal/oral:

MEDICAL CONDITIONS AND MEDICATIONS

Please list ALL your medical conditions, the medication(s) you are taking for them (if any), how long you have been on the medication

Medical Condition	**Name of Medication**	**Dosage** **How often you take it**	**How long have you been on the medication**
Example - Hypertension	*Tenormin*	*50mg 1 daily*	*2 years*

Reviewed with Patient _____

Drs Initials & Date

Name	DOB	Date

PAST SURGICAL AND HOSPITAL HISTORY: ☐ **None** ☐ **Yes, if yes**

Please describe your past experience with, **operations**, serious injuries, all and any hospitalizations and related treatments. Please include dates (month/year) of any surgeries.

FAMILY HISTORY

Are there medical events in your family's history, including diseases that may be hereditary or place you at risk? Please circle **Y** or **N** for each condition and **F** - father, **M** – Mother, **S** - Sibling (no blanks please ☺)

Condition	Yes/No	Who
Adopted	Y / N	N/A
Asthma	Y / N	F / M / S
Bleeding problems	Y / N	F / M / S
Breast disease	Y / N	F / M / S
Breast CA	Y / N	F / M / S
Cancer (indicate type)	Y / N	F / M / S
Diabetes	Y / N	F / M / S
Heart disease	Y / N	F / M / S
High blood pressure	Y / N	F / M / S
Kidney disease	Y / N	F / M / S
Stroke	Y / N	F / M / S
Thyroid disease	Y / N	F / M / S
Other	Y / N	F / M / S

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Drug / Alcohol Use Yes No Drinks/week:

Current Smoker ☐ Yes ☐ No # of cigarettes/day:

Former Smoker ☐ Yes ☐ No

Never Smoked ☐

Highest level of Education

Employment (please include job title)

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Other

Ethnicity: ☐ Latino / Hispanic ☐ Other ☐ Refused

REVIEW OF SYSTEMS

Do you have or have you had any serious or chronic medical conditions?

Please Circle **Y** or **N** or any condition(s) you have had or that you have currently. (no blanks please ☺)

		Yes	No		Yes	No		Yes	No
Constitutional:	Weight change	Y	N	Fatigue	Y	N			
Eyes:	Vision changes	Y	N	Cataracts	Y	N	Glaucoma	Y	N
Ears/Nose/Mouth/Throat:	Ulcers	Y	N	URI (upper respiratory infection)	Y	N			
Cardiovascular:	Heart conditions	Y	N	Orthopnea (difficulty breathing when lying down)	Y	N	DOE (difficulty breathing on exertion)	Y	N
Respiratory:	SOB (short of breath)	Y	N	Wheezing	Y	N			
Gastrointestinal:	Nausea/Vomiting	Y	N	Diarrhea	Y	N	Bloody Stool	Y	N
Musculoskeletal:	Weakness	Y	N						
Integumentary/Skin:	Rash	Y	N						
Neurological:	Seizure	Y	N	Syncope (fainting)	Y	N	Neuropathy	Y	N
Psychiatric:	Depression	Y	N	Anxiety	Y	N			
Endocrine:	Hot flashes	Y	N	Diabetes	Y	N	Thyroid	Y	N
Hematologic/Lymphatic:	Easy bruising	Y	N	Bleeding	Y	N	Adenopathy (Swollen Glands)	Y	N
Allergic/Immunologic:	Seasonal	Y	N	Animal Dander / Foods	Y	N			

Other:

Patient Signature _____ Date _____

Reviewed with Patient _____

Drs Initials & Date

PELVIC FLOOR DISTRESS INVENTORY

NAME _____ DATE _____

Please answer each question by checking the best response. While answering these questions, please consider your symptoms over the last 3 months. We realize that you may not be having problems in some of these areas but please fill out both sides of this form as completely as possible.

Urinary Distress Inventory 6 (UDI-6)

Do you experience, and, if so, how much are You bothered by	Not at all	Somewhat	Moderately	Quite a bit
Usually experience frequent urination?				
Usually experience urine leakage associated with a feeling of urgency, this is, a strong sensation of needing to go to the bathroom?				
Usually experience urine leakage related to coughing, sneezing, or laughing?				
Usually experience small amounts of urine leakage (that is, drops)?				
Usually experience difficulty emptying your bladder?				
Usually experience pain or discomfort in the lower abdomen or genital region?				

Colorectal-Anal Distress Inventory 8 (CRADI-8)

Do you experience, and, if so, how much are You bothered by	Not at all	Somewhat	Moderately	Quite a bit
Feel you need to strain too hard to have a bowel movement?				
Feel you have not completely emptied your bowel at the end of a bowel movement?				
Usually lose stool beyond your control if your stool is well formed?				
Usually lose stool beyond your control if your stool is loose?				
Usually lose gas from the rectum beyond your control?				
Do you usually have pain when you pass your stool?				
Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?				
Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?				

Reviewed with Patient _____/____/____
Drs Initials & Date

Please complete other side →

NAME _____ DATE _____

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)

Do you experience, and, if so, how much are You bothered by	Not at all	Somewhat	Moderately	Quite a bit
Usually experience pressure in the lower abdomen?				
Usually experience heaviness or dullness in the pelvic area?				
Usually have a bulge or something falling out that you can see or feel in your vaginal area?				
Ever have to push on the vagina or around the rectum to have or complete a bowel movement?				
Usually experience a feeling of incomplete bladder emptying?				
Ever have to push up on the bulge in the vaginal area with your fingers to start or complete urination?				

Pelvic Floor Impact Questionnaire

Instructions: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feeling. For each question place an **X** in the response that best describes how much you're activities, relationships, or feelings have been affected by your bladder, bowel, or vaginal symptoms or conditions **over the last 3 months**. Please make sure you mark an answer in **all 3 columns** for each question.

How do symptoms or conditions relate to the following →→→ Usually affect your ↓	***Bladder or Urine***	***Bowel or Rectum***	***Vagina or Pelvis***
1. Ability to do household chores (cooking, housecleaning, laundry)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
3. Entertainment activities such as going to a movie or concert?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
4. Ability to travel by car or bus for a distance greater that 30 minutes away from home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
5. Participating in social activities outside your home>	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
6. Emotional health (nervousness, depression, etc)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
7. Feeling frustrated?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

Reviewed with Patient _____/____/____
Drs Initials & Date

Princeton Urogynecology

Date_____

Patient's Name_____

New Patient Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire

Instructions: Following are a list of questions about you and your partner's sex life. All information is strictly confidential. Your confidential answers will be used only to help doctors understand what is important to patients about their sex lives. Please check the box that best answers the question for you. While answering the questions, consider your sexuality over the past six months. Thank you for your help.

☐ Sexually not active (Please do not fill out the rest of the form)

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 your 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

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Bladder Record

Princeton
UROGYNECOLOGY

Heather van Raalte, MD

Please keep track of your fluid intake and urine output for two 24-hour periods. The 24-hour periods do not have to be consecutive days. Be sure to include a.m. and p.m. when documenting the time of day you urinate, and measure the amount you urinate in ounces or cc's. These markings can be found on a measuring cup. This record is very important in deciding the treatment for your bladder problems.

Day One

Time	Amount Voided	Amount of Leakage	Reason for Accident	Amount of Fluid I Drank

Number of pads or undergarments used today: _____ *Date:* _____

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UROGYNECOLOGY

Heather van Raalte, MD

Bladder Record, *continued recorded information*

Day Two

Time	Amount Voided	Amount of Leakage	Reason for Accident	Amount of Fluid I Drank

Number of pads or undergarments used today: _____ *Date:* _____