



University of South Florida
Female Pelvic Medicine and Reconstructive Surgery

(813) 259-8500

Welcome to our practice!

When you come to see a new doctor, you may have questions about what to expect at your first visit. We hope this letter will prepare you. Our specialty group is exclusively devoted to the treatment of women with pelvic floor disorders. You can read more about our individual doctors on the University of South Florida website at www.usfurogyn.com. You may also be interested to visit the website of the *American Urogynecology Society* at www.augs.org, and the *Society of Gynecologic Surgeons* (www.sgsonline.org) to learn more about your specific condition.

Our office is located on the 4th floor of the USF South Tampa Center for Advanced Healthcare, 2 Tampa General Drive. If your appointment is at our Sarasota Office, we are at 1931 S. Tuttle Ave, Suite 1, Sarasota. When checking in, our service representative will request the following information:

- Insurance card and co-payment, if applicable
- Physician referral, if required by insurance provider
- Name and address of referring physician (**This is very important !**)
- Completed health history form (enclosed)
- Copies of other medical records, if appropriate
- Current medication bottle(s)

We do our best to see our patients in a timely fashion. No one – not even the doctors – like to run behind schedule. Nonetheless, this could occur due to a problem with a patient requiring more time than originally expected. We will let you know if we are running behind when you check in. We have enclosed a comprehensive health history questionnaire for you to complete prior to coming in for your visit. This form will give our doctors some very important information about your medical history, which will enable us to provide you with the best care possible. The questionnaire will require about 40 minutes of your time to complete.

You will be seen in a private examination room where the nurse will measure your height, weight, and blood pressure and will review your allergies and medications. You will be asked to undress from the waist down. We may need to test your urine by passing a small catheter into your bladder to collect a sterile sample. If this is done, you will be offered a low dose antibiotic to reduce the chance of urinary tract infection.

After your nursing assessment, one of the doctors will take your medical history. We use a team approach for your best medical and surgical care and it may be difficult for you to remember everyone you see. Don't hesitate to ask your caregivers their name or the role they have in your care. Keep in mind that USF is an

academic institution where future doctors are trained. The following explains the differences between those you might see:

Medical Student	A medical student is not a licensed physician. Because he or she is still in medical school, they will participate only as an observer in your care. With your permission, the medical student may interview you regarding your medical history.
Resident	A resident has completed medical school and is a licensed physician. A resident is still in training and is focusing, in this case, on the specialty of obstetrics and gynecology or urology.
Fellow	A fellow has completed medical school, has completed a 4-year residency in obstetrics and gynecology or urology and is now concentrating on his/her specialty of interest, in this case, urogynecology. A fellow will be active in your office and surgical care.
Physician Assistant or Nurse Practitioner	A nurse practitioner (NP) or physician assistant (PA) may also participate in your care. The NP or PA may see you for your pre and postoperative visits, as well as your follow-up visits to our practice. The NP/PA is a fully licensed, advanced practice healthcare professional, specially trained to care for you in our clinic setting.
Attending Physician	The attending physician is fully licensed and has completed medical school, a residency program, and fellowship training. This physician is directly responsible for your medical and surgical care and will complete your first examination and answer questions about your diagnosis and treatment plan.

After the doctor has recorded your medical history, you will be examined. You may need to be examined while standing, as well as lying down with your feet in the supports. You may lose urine or bowel contents during portions of the examination. This is actually a very important finding and we hope to make you comfortable enough so that you do not feel embarrassed. Following the examination, the doctors will discuss any tests that are recommended, as well as treatments that may be offered to you.

You may be offered an invitation to participate in one of our national women's health studies. These studies help expand our knowledge about women's health care. If you wish to participate in a national study, you will meet a study coordinator (study nurse) who will spend time discussing your potential involvement in this voluntary activity.

We now use an electronic medical record to document your care. This allows our team to enter information directly into your record while you are here. Your referring physician will be sent a letter documenting your care after your visit, usually the same day. For this reason, it is important that you provide us with the name and address of your referring physician.

When your visit is complete, you will return to the reception desk. Our service representatives will give you printed information about your visit and answer questions about scheduling future tests or treatments.

Our team is devoted to providing you with the highest quality of female pelvic medical and surgical care. Let us know if we do not meet your expectations so we can address them promptly. If you think we can improve our care in any way, feel free to make suggestions. Our patients suggested much of what we do today.

Sincerely,

Lennox Hoyte, MD.
Associate Professor and Director,

Stuart Hart MD
Assistant Professor

Division of Female Pelvic Medicine and Reconstructive Surgery



A. Patient History

- 1. Appointment Date: ____/____/____
- 2. ID: _____
- 3. Patient name: Last _____ First _____
- 4. Birth Date: ____/____/____
- 5. Occupation: _____
- 6. Age: _____
- 7. Current city/town: _____ 8. Current Zip Code: _____
- 9. Primary language: _____
- 10. Marital status: Single Married Divorced Widowed Living with partner
- 11. School completed: High School College Graduate degree Other: _____
- 12. Ethnicity: Caucasian African American Hispanic North Asian
 South Asian Pacific Islander Native American Other: _____

Main support person(spouse, partner, etc) _____
Relationship of main support person: _____
Occupation of main support person: _____
Telephone number of main support person: _____

Referring Physician: _____ Primary Physician: _____
Address: _____

Phone #: _____

B. History of Present Illness

Please describe the nature of the problem that brought you to our clinic:

Have you seen any other physicians for this problem? If yes, please list the physician and any evaluation or therapy.

When did this problem start? _____
What have you tried for relief? _____
What makes the problem better? _____
Does anything worsen the problem? _____
How severe is the problem now? _____

C. Urogyn

Genitourinary

- 1. In a typical day, how many times do you urinate?: (*frequency*) _____
- 2. In a typical night, how many times do you awaken to urinate?: (*nocturia*) _____
- 3. Do you leak urine when you do not want to (*SUI*)?: No Yes *If yes, check any conditions that cause you to leak:*
 - 3a. Coughing Sneezing Laughing Exercise Upon standing
 - Housework Lifting Intercourse
- 4. In a typical day, do you experience frequent, strong urges to urinate?: (*urgency*) No Yes
 - 4a. *If yes, do you leak urine during these strong urges: (urge incontinence)* No Yes
- 5. In a typical week, do you have **difficulty emptying your bladder**?: No Yes
- 6. Do you wear **pads**: No Yes:
 - 6a. *If yes, how many pads do you wear per day?* _____
- 7. How much fluids do you drink in a typical day? (*fluid intake*) _____
- 8. Please list any **overactive bladder medicines** you have tried and duration of use? _____

Gastrointestinal

- 9. In a typical week, how many **bowel movements** do you have?: _____
- 10. In a typical week, how many **laxatives** do you use?: _____
- 11. In a typical week, do you have **difficulty having bowel movements**?: No Yes
- 12. In a typical week, do you leak stool when you do not want to?: (*fecal incontinence*) No Yes
- 13. In a typical week, do you leak gas when you do not want to?: (*flatal incontinence*) No Yes

Gynecologic

- 14. Do you feel that your bladder, uterus, vagina or rectum are falling out?: (*prolapse symptoms*) No Yes
- 15. Are you currently **sexually active**?: No Yes
 - 15a. Do you have any **physical problems** with sexual relations?: No Yes
 - 15b. Do you have pain with sexual intercourse?: (*dyspareunia*) No Yes

D. Cancer Screening

- Date of last pap smear: _____ / _____ Was it: normal / abnormal
- History of abnormal pap smears?: yes / no If yes, please explain: _____
- Date of last mammogram: _____ / _____ Was it: normal / abnormal
- History of abnormal mammograms?: yes / no If yes, please explain: _____
- Date of last colonoscopy: _____ / _____ Was it: normal / abnormal
- If abnormal, please explain: _____
- Have you received a Cervical Cancer Vaccination? Yes / No : If yes, please give the date: _____



E. Allergies

(Please list any drug allergies)

<u>Medication</u>	<u>Reaction</u>	<u>Medication</u>	<u>Reaction</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

F. Medications

(Please list any over the counter medications in addition to prescribed medicines)

<u>Medication name</u>	<u>Dose</u>	<u>Frequency</u>	<u>Prescribing Physician</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

G. Past Medical History

(Please check any medical problems you were diagnosed with as an adult)

- Heart disease
- High Blood Pressure
- Diabetes
- COPD
- Cancer: _____
- Heart attack
- Stroke
- Blood clots (DVT, etc.)
- Pulmonary embolism
- Asthma
- Heart murmur
- Thyroid disease
- Lupus
- Uterine cancer
- Ovarian cancer
- Pelvic radiation for cancer
- Bladder cancer

Serious injuries (Please explain): _____

Procedures to your cervix (Conization, LEEP, etc.). Please list procedure, reason for procedure and date of procedure: _____

<u>Other Medical Diagnoses (please list)</u>	<u>Date of Diagnosis</u>	<u>Treating Physician</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



I. Obstetrical History

Please list number of:

Pregnancies(All pregnancies)_____ Miscarriages_____ Abortions_____ Living Children_____

No	Birth Date	Birth Weight	Male/Female	Weeks/Months of pregnancy	Type of Delivery	Tears into Rectum Y/N
1	__/__/__	_____	M / F	_____ weeks / months	Vaginal / C/section / Vacuum / Forceps	----- Y / N -----
2	__/__/__	_____	M / F	_____ weeks / months	Vaginal / C/section / Vacuum / Forceps	----- Y / N -----
3	__/__/__	_____	M / F	_____ weeks / months	Vaginal / C/section / Vacuum / Forceps	----- Y / N -----
4	__/__/__	_____	M / F	_____ weeks / months	Vaginal / C/section / Vacuum / Forceps	----- Y / N -----
5	__/__/__	_____	M / F	_____ weeks / months	Vaginal / C/section / Vacuum / Forceps	----- Y / N -----
6	__/__/__	_____	M / F	_____ weeks / months	Vaginal / C/section / Vacuum / Forceps	----- Y / N -----
7	__/__/__	_____	M / F	_____ weeks / months	Vaginal / C/section / Vacuum / Forceps	----- Y / N -----
8	__/__/__	_____	M / F	_____ weeks / months	Vaginal / C/section / Vacuum / Forceps	----- Y / N -----

J. Gynecologic History

Menstrual History

How old were you when you had your first period? _____

First day of last menstrual cycle:_____/_____/_____ Age of menopause(if applicable):_____

How often do you have a menstrual cycle:_____ Length of bleeding:_____

If abnormal cycles, please explain:_____

If you are sexually active, what birth control (if any) do you use?: _____ None

History of sexually transmitted diseases?: yes / no If yes, please explain:_____

K. Social History

	No	Yes	
1. Do you smoke currently?			If yes: _____ # packs per day for _____ years
2. Did you smoke in the past?			If yes, when did you quit?_____
3. Do you drink alcohol?			If yes, how much:_____
4. Do you use any street drugs			If yes, please explain:_____
5. Do you exercise regularly			If yes, please describe:_____
6. Do you drink caffeine			If yes, please describe:_____

L Family History.

Has anyone in your family had any of these diseases? If so, please give relationship to you.

- 1. Breast cancer:_____
- 2. Heart disease:_____
- 3. Ovarian cancer:_____
- 4. Colon cancer:_____
- 5. Prolapse (including cystocele or rectocele):_____
- 6. Urinary Incontinence:_____
- 7. Other disease(s), please list:_____

M. Review of Systems

(In the past 7 days, have you been bothered by any of the symptoms below?)

- Constitutional: Fever Fatigue Weight change
 Loss of appetite
- Eyes: Eye pain Blurry vision Loss of vision
- ENMT: Swollen neck glands Loss of hearing
- Cardiovascular: Chest pain Heart palpitations Leg swelling
 Fainting (syncope) Heart murmur
- Respiratory: Shortness of breath Wheezing Frequent coughing
- Gastrointestinal: Abdominal pain Constipation Diarrhea
 Blood in stool Vomiting Nausea
 Decreased appetite
- Genitourinary: Abnormally heavy bleeding Irregular menstrual cycles
 Painful intercourse Abnormal discharge
 Urinary urgency Urinary frequency
 Painful urination Blood in urine
- Musculoskeletal: Joint pain Joint stiffness Back pain
 Difficulty walking Muscle pain Muscle weakness
- Neurological: Frequent headaches Frequent dizziness Seizures
- Skin: Rash Itching
- Breast: Breast mass Breast pain Nipple discharge
- Psychiatric: Depression Anxiety Memory loss or confusion
- Endocrine: Diabetes Hyperthyroidism Hypothyroidism

Patient signature

Date

Physician signature(Above information was reviewed)

Date

Urinary Questionnaire I (MESA)

Instructions:

These questions ask about symptoms you may have related to urine leakage. Please indicate the response that best represents how frequently you experience each symptom by placing an “X” under the appropriate response..

Part I: (Stress Symptoms)

	Never	Rarely	Sometimes	Often
Does coughing gently cause you to lose urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Never	Rarely	Sometimes	Often
Does coughing hard cause you to lose urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Never	Rarely	Sometimes	Often
Does sneezing cause you to lose urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Never	Rarely	Sometimes	Often
Does lifting things cause you to lose urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Never	Rarely	Sometimes	Often
Does bending cause you to lose urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Never	Rarely	Sometimes	Often
Does laughing cause you to lose urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Never	Rarely	Sometimes	Often
Does walking briskly or jogging cause you to lose urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Never	Rarely	Sometimes	Often
Does straining, if you are constipated, cause you to lose urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Never	Rarely	Sometimes	Often
Does getting up from a sitting to a standing position cause you to lose urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the last **7 days**, how many times did you accidentally leak urine when you were performing some physical activity such as coughing, sneezing, lifting or exercise? # of times _____

Urinary Questionnaire I (MESA)

Instructions:

These questions ask about symptoms you may have related to urine leakage. Please indicate the response that best represents how frequently you experience each symptom by placing an “X” under the appropriate response..

Part II: (Urge Symptoms)

	Never	Rarely	Sometimes	Often
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?				
	Never	Rarely	Sometimes	Often
If you can't 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?				
	Never	Rarely	Sometimes	Often
Do you lose urine when you suddenly have he feeling that your bladder is very full?				
	Never	Rarely	Sometimes	Often
Does washing your hands cause you to lose urine?				
	Never	Rarely	Sometimes	Often
Does cold weather cause you to lose urine?				
	Never	Rarely	Sometimes	Often
Does drinking cold beverages cause you to lose urine?				
	Never	Rarely	Sometimes	Often
During the last 7 days, how many times did you accidentally leak urine when you had the urge or the feeling that you needed to empty your bladder, but you could not get to the toilet fast enough?				

of times in the past 7 days? _____

Pelvic Floor Questionnaire (PFDI)

Instructions:

Please answer the following questions by placing an “X” in the appropriate box. If you are unsure about how to answer a question, give the best answer you can. While answering these questions, please consider your symptoms over the **last three months**. Thank you for your help.

Date: ____ / ____ / ____

1	Do you usually experience <i>pressure</i> in the lower abdomen?	No 0	Yes <input type="checkbox"/>	If yes, how much does this bother you?	Not at all 1	Somewhat 2	Moderately 3	Quite a bit 4
2	Do you usually experience <i>heaviness or dullness</i> in the pelvic area?	No 0	Yes <input type="checkbox"/>	If yes, how much does this bother you?	Not at all 1	Somewhat 2	Moderately 3	Quite a bit 4
3	Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	No 0	Yes <input type="checkbox"/>	If yes, how much does this bother you?	Not at all 1	Somewhat 2	Moderately 3	Quite a bit 4
4	Do you usually have to push on the vagina or around the rectum to have or complete bowel movement?	No 0	Yes <input type="checkbox"/>	If yes, how much does this bother you?	Not at all 1	Somewhat 2	Moderately 3	Quite a bit 4
5	Do you usually experience a feeling of incomplete bladder emptying?	No 0	Yes <input type="checkbox"/>	If yes, how much does this bother you?	Not at all 1	Somewhat 2	Moderately 3	Quite a bit 4
6	Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	No 0	Yes <input type="checkbox"/>	If yes, how much does this bother you?	Not at all 1	Somewhat 2	Moderately 3	Quite a bit 4
7	Do you feel you need to strain too hard to have a bowel movement?	No 0	Yes <input type="checkbox"/>	If other than never, how much does this bother you?	Not at all 1	Somewhat 2	Moderately 3	Quite a bit 4
8	Do you feel you have not completely emptied your bowels at the end of a bowel movement?	No 0	Yes <input type="checkbox"/>	If other than never, how much does this bother you?	Not at all 1	Somewhat 2	Moderately 3	Quite a bit 4
9	Do you usually lose stool beyond your control if your stool is well formed?	No 0	Yes <input type="checkbox"/>	If yes, how much does this bother you?	Not at all 1	Somewhat 2	Moderately 3	Quite a bit 4
10	Do you usually lose stool beyond your control if your stool is loose or liquid?	No 0	Yes <input type="checkbox"/>	If yes, how much does this bother you?	Not at all 1	Somewhat 2	Moderately 3	Quite a bit 4

11	Do you usually lose gas from the rectum beyond your control?	<table border="1"> <thead> <tr> <th>No</th> <th>Yes</th> </tr> </thead> <tbody> <tr> <td>0</td> <td></td> </tr> </tbody> </table>	No	Yes	0		If yes, how much does this bother you?	<table border="1"> <thead> <tr> <th>Not at all</th> <th>Somewhat</th> <th>Moderately</th> <th>Quite a bit</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> </tbody> </table>	Not at all	Somewhat	Moderately	Quite a bit	1	2	3	4
No	Yes															
0																
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12	Do you usually have pain when you pass your stool?	<table border="1"> <thead> <tr> <th>No</th> <th>Yes</th> </tr> </thead> <tbody> <tr> <td>0</td> <td></td> </tr> </tbody> </table>	No	Yes	0		If yes, how much does this bother you?	<table border="1"> <thead> <tr> <th>Not at all</th> <th>Somewhat</th> <th>Moderately</th> <th>Quite a bit</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> </tbody> </table>	Not at all	Somewhat	Moderately	Quite a bit	1	2	3	4
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13	Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	<table border="1"> <thead> <tr> <th>No</th> <th>Yes</th> </tr> </thead> <tbody> <tr> <td>0</td> <td></td> </tr> </tbody> </table>	No	Yes	0		If other than never, how much does this bother you?	<table border="1"> <thead> <tr> <th>Not at all</th> <th>Somewhat</th> <th>Moderately</th> <th>Quite a bit</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> </tbody> </table>	Not at all	Somewhat	Moderately	Quite a bit	1	2	3	4
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14	Does a part of your bowel every pass through the rectum and bulge outside during or after a bowel movement?	<table border="1"> <thead> <tr> <th>No</th> <th>Yes</th> </tr> </thead> <tbody> <tr> <td>0</td> <td></td> </tr> </tbody> </table>	No	Yes	0		If yes, how much does this bother you?	<table border="1"> <thead> <tr> <th>Not at all</th> <th>Somewhat</th> <th>Moderately</th> <th>Quite a bit</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> </tbody> </table>	Not at all	Somewhat	Moderately	Quite a bit	1	2	3	4
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15	Do you usually experience frequent urination?	<table border="1"> <thead> <tr> <th>No</th> <th>Yes</th> </tr> </thead> <tbody> <tr> <td>0</td> <td></td> </tr> </tbody> </table>	No	Yes	0		If yes, how much does this bother you?	<table border="1"> <thead> <tr> <th>Not at all</th> <th>Somewhat</th> <th>Moderately</th> <th>Quite a bit</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> </tbody> </table>	Not at all	Somewhat	Moderately	Quite a bit	1	2	3	4
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16	Do you usually experience urine leakage associated with a feeling of urgency that is a strong sensation of needing to go to the bathroom?	<table border="1"> <thead> <tr> <th>No</th> <th>Yes</th> </tr> </thead> <tbody> <tr> <td>0</td> <td></td> </tr> </tbody> </table>	No	Yes	0		If yes, how much does this bother you?	<table border="1"> <thead> <tr> <th>Not at all</th> <th>Somewhat</th> <th>Moderately</th> <th>Quite a bit</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> </tbody> </table>	Not at all	Somewhat	Moderately	Quite a bit	1	2	3	4
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17	Do you usually experience urine leakage related to coughing, sneezing, or laughing?	<table border="1"> <thead> <tr> <th>No</th> <th>Yes</th> </tr> </thead> <tbody> <tr> <td>0</td> <td></td> </tr> </tbody> </table>	No	Yes	0		If yes, how much does this bother you?	<table border="1"> <thead> <tr> <th>Not at all</th> <th>Somewhat</th> <th>Moderately</th> <th>Quite a bit</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> </tbody> </table>	Not at all	Somewhat	Moderately	Quite a bit	1	2	3	4
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18	Do you usually experience small amounts of urine leakage (that is, drops)?	<table border="1"> <thead> <tr> <th>No</th> <th>Yes</th> </tr> </thead> <tbody> <tr> <td>0</td> <td></td> </tr> </tbody> </table>	No	Yes	0		If yes, how much does this bother you?	<table border="1"> <thead> <tr> <th>Not at all</th> <th>Somewhat</th> <th>Moderately</th> <th>Quite a bit</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> </tbody> </table>	Not at all	Somewhat	Moderately	Quite a bit	1	2	3	4
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19	Do you usually experience difficulty emptying your bladder?	<table border="1"> <thead> <tr> <th>No</th> <th>Yes</th> </tr> </thead> <tbody> <tr> <td>0</td> <td></td> </tr> </tbody> </table>	No	Yes	0		If yes, how much does this bother you?	<table border="1"> <thead> <tr> <th>Not at all</th> <th>Somewhat</th> <th>Moderately</th> <th>Quite a bit</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> </tbody> </table>	Not at all	Somewhat	Moderately	Quite a bit	1	2	3	4
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Not at all	Somewhat	Moderately	Quite a bit													
1	2	3	4													
20	Do you usually experience <i>pain</i> or <i>discomfort</i> in the lower abdomen or genital region?	<table border="1"> <thead> <tr> <th>No</th> <th>Yes</th> </tr> </thead> <tbody> <tr> <td>0</td> <td></td> </tr> </tbody> </table>	No	Yes	0		If yes, how much does this bother you?	<table border="1"> <thead> <tr> <th>Not at all</th> <th>Somewhat</th> <th>Moderately</th> <th>Quite a bit</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> </tr> </tbody> </table>	Not at all	Somewhat	Moderately	Quite a bit	1	2	3	4
No	Yes															
0																
Not at all	Somewhat	Moderately	Quite a bit													
1	2	3	4													

Pain worksheet:

Instructions:

Please indicate the location(s) on the body maps below by marking, or circling the appropriate spot(s) in response to the following questions:

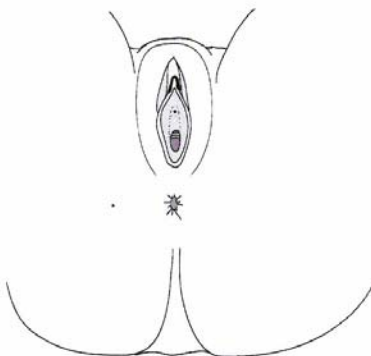
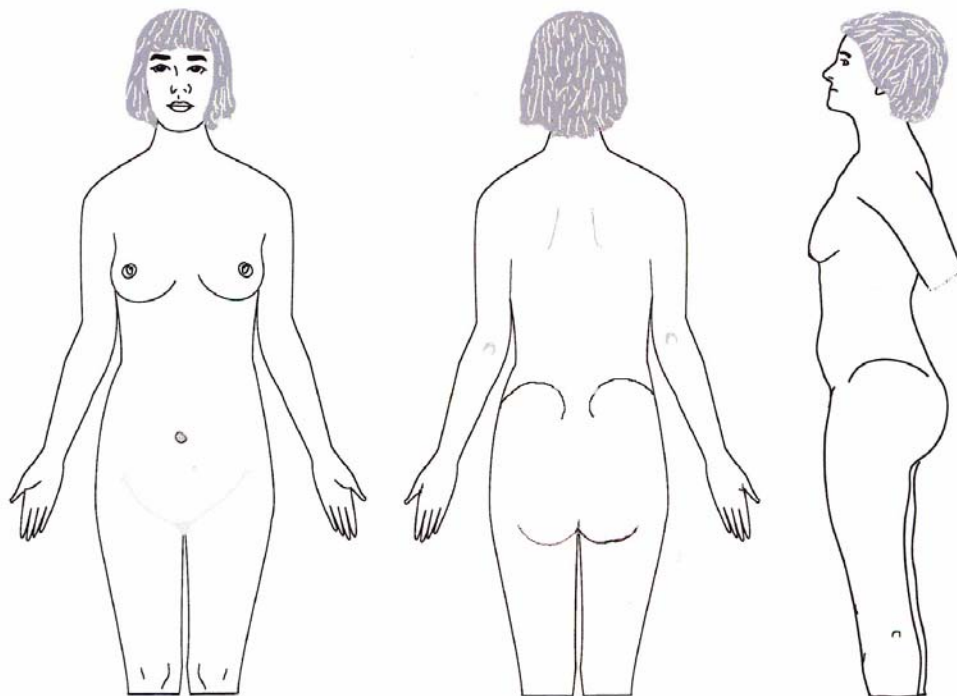
Are you in any pain or discomfort right now?

Pain level (please circle) 0 - no pain 1 2 3 4 5 6 7 8 9 10 – worst pain of my life

Please mark the location of pain below with an "X"

Discomfort level 0 - no discomfort 1 2 3 4 5 6 7 8 9 10 – worst discomfort of my life

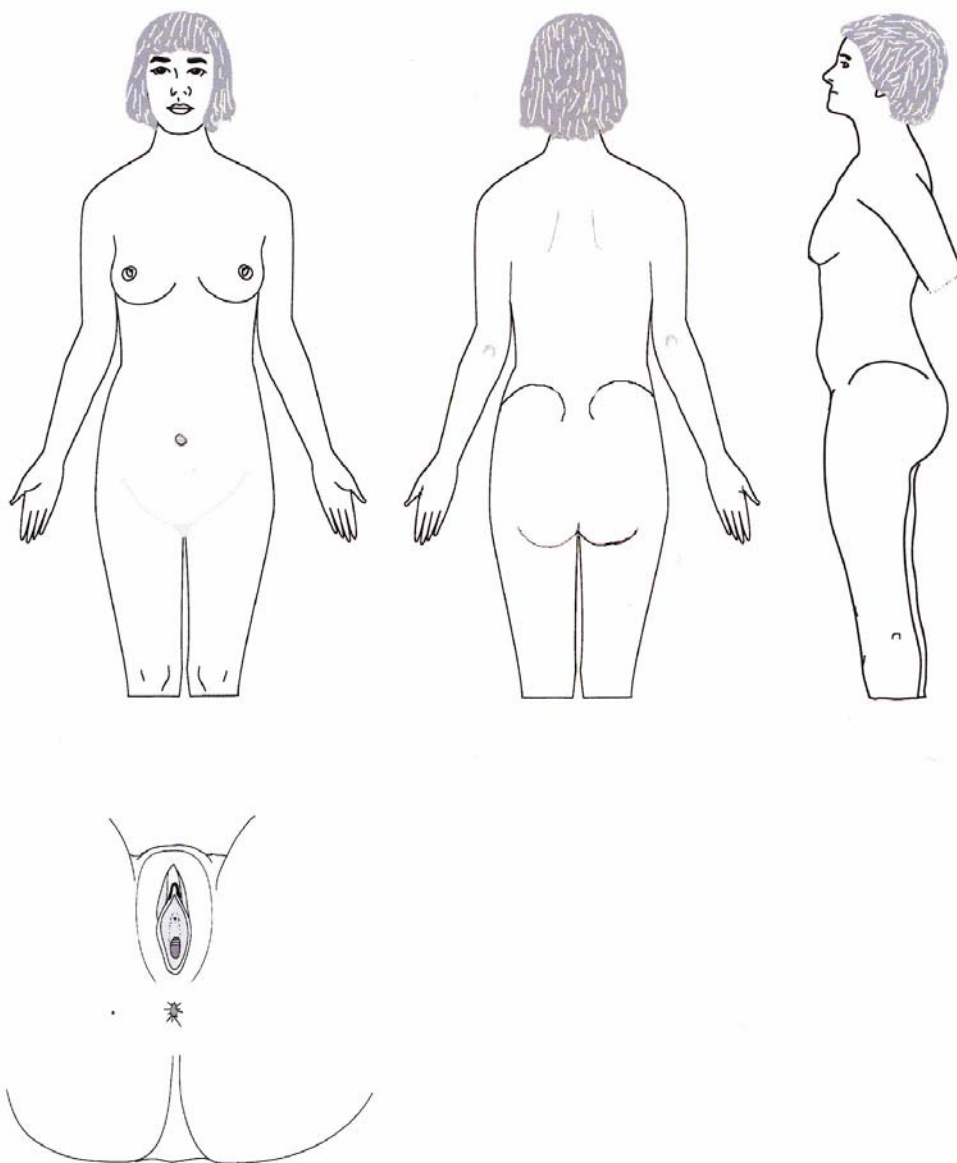
Please mark the location of discomfort below with a "O"



Bladder sensation worksheet: Instructions:

Please indicate the location(s) on the body maps below by placing an "X" or circling the appropriate spot(s) in response to the following question:

When you feel an urge to empty your bladder, where in your body is that urge located?



The Pelvic Pain and Urinary/Frequency (PUF) Patient Symptom Scale

Please circle the answer that best describes how you feel for each question.

	0	1	2	3	4	Symptom Score	Bother Score
1. How many times do you go to the bathroom during the day?	3-6	7-10	11-14	15-19	20+		
2a. How many times do you go to the bathroom at night?	0	1	2	3	4+		
2b. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe			
3. Are you currently sexually active? Yes ___ No ___							
4a. If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always			
4b. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
5. Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes, or scrotum)?	Never	Occasionally	Usually	Always			
6. Do you have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7a. If you have pain, is it usually...		Mild	Moderate	Severe			
7b. Does your pain bother you?	Never	Occasionally	Usually	Always			
8a. If you have urgency, is it usually...		Mild	Moderate	Severe			
8b. Does your urgency bother you?	Never	Occasionally	Usually	Always			
Symptom Score (1, 2a, 4a, 5, 6, 7a, 8a) =							
Bother Score (2b, 4b, 7b, 8b) =							
Total Score (Symptom Score + Bother Score) =							

PUF Patient Symptom Scale. © 2000 C. Lowell Parsons, M.D. Used with permission.

Pelvic Floor Questionnaire (PFIQ-7)

Instructions:

Some women find tht bladder, bowel or vaginal symptoms affect their activities, relationships and feelings. For each question, plan 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 or conditions **over the last 3 months**.

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

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

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

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

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

3. Entertainment activities such as going to a movie or concert?

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

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

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

5. Participating in social activities outside your home?

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

6. Emotional health (nervousness, depression, etc.)?

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

7. Feeling frustrated?

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

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			Mean Bladder/Urine (UIQ-7) (0,1,2,3)
			Mean Colorectal-Anal (CRAIQ-7)
			Mean Vagina/Pelvis (POPIQ-7)
			Scale Bladder/Urine (UIQ-7 *33.33)
			Scale Colorectal-Anal (CRAIQ-7 * 33.33)
			Scale Vagina/Pelvis (POPIQ-7* 33.33)
			PFIQ-7 Summary (=UIQ+CRAIQ+POPIQ)



University of South Florida
USF Urogynecology and Reconstructive Surgery

You are almost finished with the questionnaire!
Only 2 pages left

The next pages ask questions about your sex life. The questions are designed to help us better understand how your symptoms are affecting your quality of life.

If you ***are sexually active and wish to complete the questionnaire***, please continue on to the next page.

If you ***have not been sexually active in the past 3 months***, please mark an **X** in the space below, and ignore all questions beyond this page.

_____ I am not sexually active

If you ***do not wish*** to answer questions about your sexual activity, please mark an **X** in the space below, and ignore all questions beyond this page.

_____ I do not wish to answer any questions about my sexual activity.

Thank you,

The USF Urogynecology and Pelvic Surgery team

Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire (PISQ-12)

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 us understand what is important to you about your sex life. Please check an (X) the box that best answers the question for you. While answering the questions, consider *your* sexuality over the past six months.

How do symptoms or condition related to the following usually affect you?

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.

Always (4)	Usually	Sometimes	Seldom	Never (0)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Do you climax (have an orgasm) when having **sexual intercourse** with your partner?

Always (4)	Usually	Sometimes	Seldom	Never (0)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Do you feel sexually excited (turned on) when having sexual activity with your partner?

Always(4)	Usually	Sometimes	Seldom	Never (0)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. How satisfied are you with the variety of sexual activities in you current sex life?

Always (4)	Usually	Sometimes	Seldom	Never(0)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Do you feel pain during sexual intercourse?

Always (0)	Usually	Sometimes	Seldom	Never (4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Are you incontinent of urine (leak urine) with sexual activity?

Always (0)	Usually	Sometimes	Seldom	Never (4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Does fear of incontinence (either stool or urine) restrict your sexual activity?

Always (0)	Usually	Sometimes	Seldom	Never(4)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8.	Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum or vagina falling out)?				
	Always (0)	Usually	Sometimes	Seldom	Never (4)
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
9.	When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?				
	Always (0)	Usually	Sometimes	Seldom	Never(4)
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
10.	Does your partner have a problem with erections that affects your sexual activity?				
	Always(0)	Usually	Sometimes	Seldom	Never(4)
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
11.	Does your partner have a problem with premature ejaculation that affects your sexual activity?				
	Always(0)	Usually	Sometimes	Seldom	Never(4)
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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 (0)	Less intense	Same intensity	More intense	Much more intense (4)
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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Scoring

Scores are calculated by totaling the scores for each question with 0=never, 4=always. Reverse scoring is used for items 1,2,3 and 4. The short form questionnaire can be used with up to two missing responses. To handle missing values the sum is calculated by multiplying the number of items by the mean of the answered items. If there are more than two missing responses, the short form no longer accurately predicts long form scores. Short form scores can only be reported as total or on an item basis. Although the short form reflects the content of the three factors in the long form, it is not possible to analyze data at the factor level. To compare long and short form scores multiply the short form score by 2.58