Female Pelvic Medicine and Reconstructive Surgery - UroGynecology
South Tampa Office - 2 Tampa General Circle, 4th Floor, Tampa, FL 33606
Morsani Center USF Campus - 13330 USF Laurel Drive, 5th Floor Tampa, FL 33612
Tel: 813-259-8500 Fax: 813-259-8582

NEW PATIENT PACKET

Patient History

Location: ☐ South Tampa ☐ Morsani Center

Appointment Date: ____/____/_____

Patient name: Last_____First_____Birth Date:_____/_____/_____

Occupation:_____ Age:_____

Current city/town:_____Current Zip Code:_____ Primary language:_____

Home Telephone: _____ Cell Phone:_____Work Phone: _____

**May we leave a message on your home and/or cell phone concerning your care here? ☐ Yes☐ No

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Living with partner

School completed: ☐ High School ☐ College ☐ Graduate degree ☐ Other_____

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:_____ Address: _____
_____ _____
_____ _____

Phone #:_____ Phone #: _____

History of Present Illness

Please briefly 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?_____

Urogynecology History

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 (***stress incontinence***)?: □ 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

(Urogynecology History Continued)

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 do you drink in a typical day? (***fluid intake***) _____
8. Please list any **overactive bladder medicines** you have tried and how long did you use them?_____

_____

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)*** □ No □ Yes
15. Are you currently **sexually active**? □ No □ Yes
16. Do you have any **physical problems** with sexual relations? □ No □ Yes
17. Do you have **pain** with sexual intercourse? (***dyspareunia***) □ No □ Yes

Cancer Screening

Date of last pap smear: _____/_____ Was it: normal / abnormal History of abnormal pap smears? □ No □ Yes

If abnormal or history of abnormal paps, please explain:_____

Date of last mammogram: _____/_____Was it: normal / abnormal History of abnormal mammograms? □ No □Yes

If yes, please explain:_____

Date of last colonoscopy: _____/_____ Was it: normal / abnormal History of abnormal colonoscopies? □ No □Yes

If yes, please explain:_____

Have you received a Cervical Cancer Vaccination? □ No □Yes: If yes, please give the date:_____

Allergies

(Please list any drug allergies)

Medication	Reaction	Medication	Reaction

Medications

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

Medication name	Dose	Frequency	Prescribing Physician

Continue on back if needed

Past Medical History

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

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

□ Cancer:_____

Serious injuries (Please explain):_____

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

_____

Other Medical Diagnoses (please list)	Date of Diagnosis	Treating Physician

Past Surgical History

(Please list any previous surgeries/operations)

Hysterectomy Date of operation:_____

Please check the type of hysterectomy □ Abdominal incision □ Laparoscopic □ Vaginal □ Supracervical

□ Both ovaries were removed □ Right ovary was removed □ Left ovary was removed

Reason for surgery:_____

Any other procedures performed during surgery:_____

Removal of ovaries as a separate surgery Date of operation:_____

Please check the type of surgery

□ Laparoscopy □ Abdominal incision □ Both ovaries were removed □ Right was removed □ Left was removed

Reason for surgery:_____

Any other procedures performed during surgery:_____

Other Gynecologic surgeries

□ Tubal ligation Reason and date of surgery:_____

□ Laparoscopy Reason and date of surgery: _____

□ Exploratory laparotomy Reason and date of surgery:_____

□ **Vaginal suspension** Reason and date of surgery:_____

□ **Cystocele repair** Reason and date of surgery:_____

□ **Rectocele repair** Reason and date of surgery:_____

□ **Bladder tack** Reason and date of surgery:_____

□ **Incontinence surgery**

□ Suburethral Sling Reason and date of surgery:_____

□ Burch Reason and date of surgery:_____

□ MMK Reason and date of surgery:_____

□ Collagen Reason and date of surgery:_____

□ **Other Abdominal surgeries**

□ Appendectomy Reason and date of surgery:_____

□ Gallbladder removal Reason and date of surgery:_____

□ Bowel surgery Reason and date of surgery:_____

Other Surgeries or Hospitalizations (Please list)	Date	Hospital

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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 N/Y
1	/ /		M / F	weeks / months	Vaginal / C/section / Vacuum / Forceps	□ No □Yes
2	/ /		M / F	weeks / months	Vaginal / C/section / Vacuum / Forceps	□ No □Yes
3	/ /		M / F	weeks / months	Vaginal / C/section / Vacuum / Forceps	□ No □Yes
4	/ /		M / F	weeks / months	Vaginal / C/section / Vacuum / Forceps	□ No □Yes
5	/ /		M / F	weeks / months	Vaginal / C/section / Vacuum / Forceps	□ No □Yes
6	/ /		M / F	weeks / months	Vaginal / C/section / Vacuum / Forceps	□ No □Yes

(Continue on back if needed)

Gynecologic History

Menstrual History

How old were you when you had your first period?_____
Age of menopause (if applicable):_____
If abnormal cycles, please explain:_____

First day of last menstrual cycle: ____/____/____
How often do you have a menstrual cycle:_____
Length of bleeding:_____

Sexual History

If you are sexually active, what birth control (if any) do you use?: □ None □ Pill □Patch or ring □ Depo Provera (shot) □ IUD □ Condoms □ Rhythm method □ Tubal ligation □ Partner has vasectomy □ Other _____

History of sexually transmitted diseases?: □ No □Yes If yes, please explain:_____

Social History

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

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:_____

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Review of Systems

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

Constitutional:	□ Fever □ Loss of appetite	□ Fatigue	□ Weight change
Eyes:	□ Eye pain	□ Blurry vision	□ Loss of vision
ENMT:	□ Swollen neck glands	□ Loss of hearing	
Cardiovascular:	□ Chest pain □ Fainting (syncope)	□ Heart palpitations □ Heart murmur	□ Leg swelling
Respiratory:	□ Shortness of breath	□ Wheezing	□ Frequent coughing
Gastrointestinal:	□ Abdominal pain □ Blood in stool □ Decreased appetite	□ Constipation □ Vomiting	□ Diarrhea □ Nausea
Genitourinary:	□ Abnormally heavy bleeding □ Painful intercourse □ Urinary urgency □ Painful urination		□ Irregular menstrual cycles □ Abnormal discharge □ Urinary frequency □ Blood in urine
Musculoskeletal:	□ Joint pain □ Difficulty walking	□ Joint stiffness □ Muscle pain	□ Back 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

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SF-12 ®

This information will help your doctors keep track of how you feel and how well you are able to do your usual activities. Answer every question by placing a check mark on the line in front of the appropriate answer. If you are unsure about how to answer a question, please give the best answer you can and make a written comment beside your answer.

1. In general, would you say your health is:
_____Excellent (1)
_____ Very Good (2)
_____ Good (3)
_____ Fair (4)
_____ Poor (5)

The following two questions are about activities you might do during a typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities? If so, how much?

2. MODERATE ACTIVITIES, such as moving table, pushing a vacuum cleaner, bowling, or playing golf:
_____Yes, Limited A Lot (1)

_____Yes, Limited A Little (2)

_____ No, Not Limited At All (3)

3. Climbing SEVERAL flights of stairs a

_____Yes, Limited A Lot (1)

_____ Yes, Limited A Little (2)

_____ No, Not Limited At All (3)

During the PAST 4 WEEKS have you had any of the following problems with your work or other regular activities AS A RESULT OF YOUR PHYSICAL HEALTH?

4. ACCOMPLISHED LESS than you would like:

_____ Yes (1)

_____ No (2)

5. Were limited in the KIND of work or other activities:

_____ Yes (1)

_____ No (2)

During the PAST 4 WEEKS, were you limited in the kind of work you do or other regular activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

6. ACCOMPLISHED LESS than you would like:

_____ Yes (1)

_____ No (2)

7. Didn't do work or other activities as CAREFULLY as usual:

_____ Yes (1)

_____ No (2)

8. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)?
_____ Not at all (1)
_____ A Little bit (2)
_____ Moderately (3)
_____ Quite a bit (4)
_____ Extremely (5)

The next three questions are about how you feel and how things have been DURING THE PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS –

9. Have you felt calm and peaceful?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

10. Did you have a lot of energy?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

11. Have you felt downhearted and blue?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

12. During the PAST 4 WEEKS, how much of the time has your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

Total Score: _____ _____Pre op _____Post op 2-3wk _____6 month post _____1 yr. post

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?				
Does coughing hard cause you to lose urine?				
Does sneezing cause you to lose urine?				
Does lifting things cause you to lose urine?				
Does bending cause you to lose urine?				
Does laughing cause you to lose urine?				
Does walking briskly or jogging cause you to lose urine?				
Does straining, if you are constipated, cause you to lose urine?				
Does getting up from a sitting to a standing position cause you to lose urine?				

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

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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 the 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? _____

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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: _____/_____/ _____

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

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11	Do you usually lose stool beyond your control if your stool is loose or liquid?	No	Yes	If yes, how much does this bother you?	Not at all	Somewhat	Moderately	Quite a bit
		0			1	2	3	4
12	Do you usually lose gas from the rectum beyond your control?	No	Yes	If yes, how much does this bother you?	Not at all	Somewhat	Moderately	Quite a bit
		0			1	2	3	4
13	Do you usually have pain when you pass your stool?	No	Yes	If yes, how much does this bother you?	Not at all	Somewhat	Moderately	Quite a bit
		0			1	2	3	4
14	Do you sense a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	No	Yes	If yes, how much does this bother you?	Not at all	Somewhat	Moderately	Quite a bit
		0			1	2	3	4
15	Does a part of your bowel every pass through the rectum and bulge outside during or after a bowel movement?	No	Yes	If yes, how much does this bother you?	Not at all	Somewhat	Moderately	Quite a bit
		0			1	2	3	4
16	Do you usually experience frequent urination?	No	Yes	If yes, how much does this bother you?	Not at all	Somewhat	Moderately	Quite a bit
		0			1	2	3	4
17	Do you usually experience urine leakage associated with a feeling of urgency that is a strong sensation of needing to go to the bathroom?	No	Yes	If yes, how much does this bother you?	Not at all	Somewhat	Moderately	Quite a bit
		0			1	2	3	4
18	Do you usually experience urine leakage related to coughing, sneezing, or laughing?	No	Yes	If yes, how much does this bother you?	Not at all	Somewhat	Moderately	Quite a bit
		0			1	2	3	4
19	Do you usually lose stool beyond your control if your stool is loose or liquid?	No	Yes	If yes, how much does this bother you?	Not at all	Somewhat	Moderately	Quite a bit
		0			1	2	3	4
20	Do you usually experience difficulty emptying your bladder?	No	Yes	If yes, how much does this bother you?	Not at all	Somewhat	Moderately	Quite a bit
		0			1	2	3	4

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		No	Yes	If yes, how much does this bother you?	Not at all	Somewhat	Moderately	Quite a bit
21	Do you usually lose gas from the rectum beyond your control?	0			1	2	3	4
22	Do you usually have pain when you pass your stool?	0			1	2	3	4
23	Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0		If other than never, how much does this bother you?	1	2	3	4
24	Does a part of your bowel every pass through the rectum and bulge outside during or after a bowel movement?	0			1	2	3	4
25	Do you usually experience frequent urination?	0			1	2	3	4
26	Do you usually experience urine leakage associated with a feeling of urgency that is a strong sensation of needing to go to the bathroom?	0			1	2	3	4
27	Do you usually experience urine leakage related to coughing, sneezing, or laughing?	0			1	2	3	4
28	Do you usually experience small amounts of urine leakage (that is, drops)?	0			1	2	3	4
29	Do you usually experience difficulty emptying your bladder?	0			1	2	3	4
30	Do you usually experience **pain** or **discomfort** in the lower abdomen or genital region?	0			1	2	3	4

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Pain worksheet: ***Instructions:***

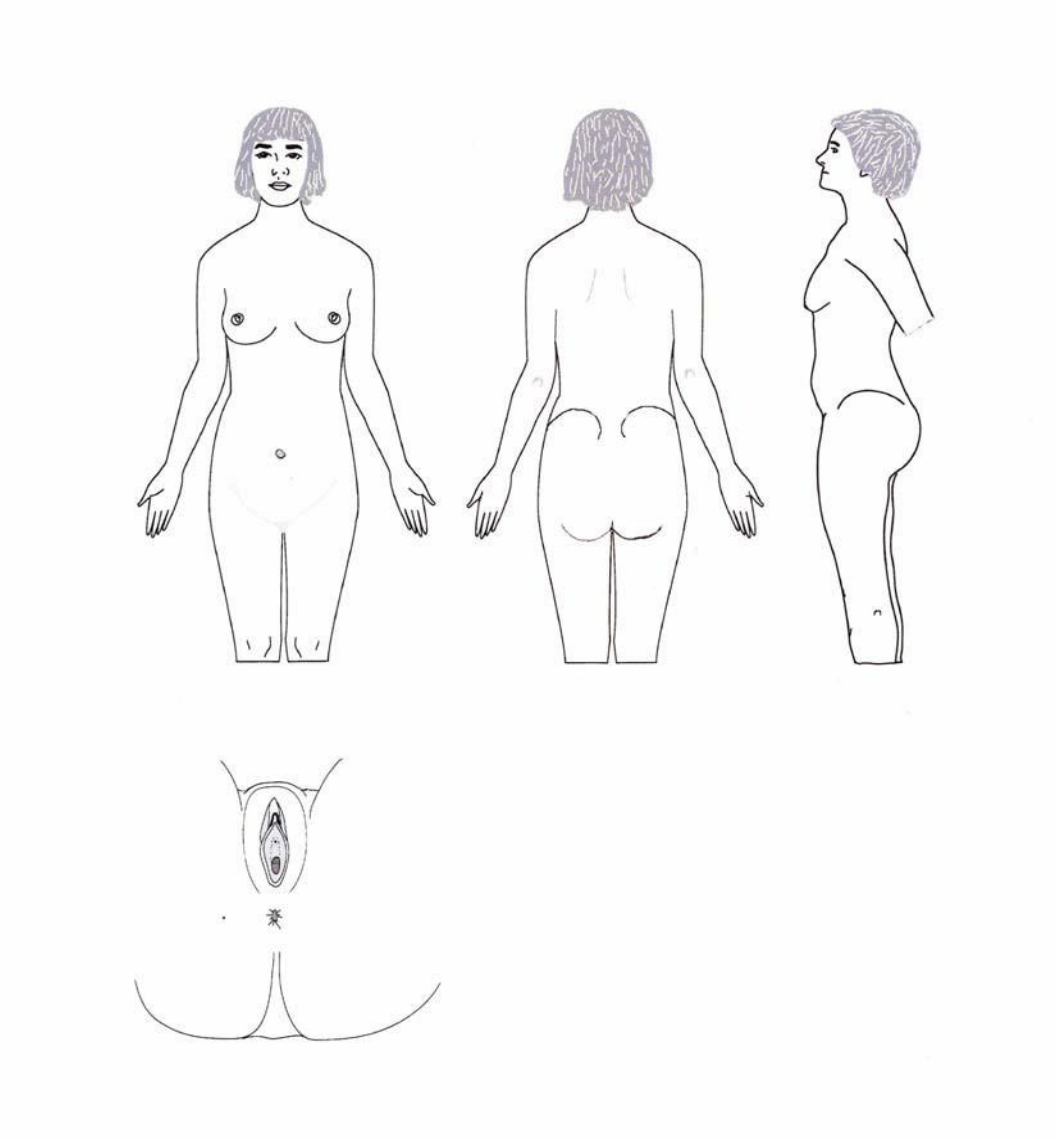
Please indicate the location(s) on the body maps below by marking, or circling the appropriate spot(s) in response to the following questions:

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 an "O"

Please mark the location with an "X" or "O" on the images below.



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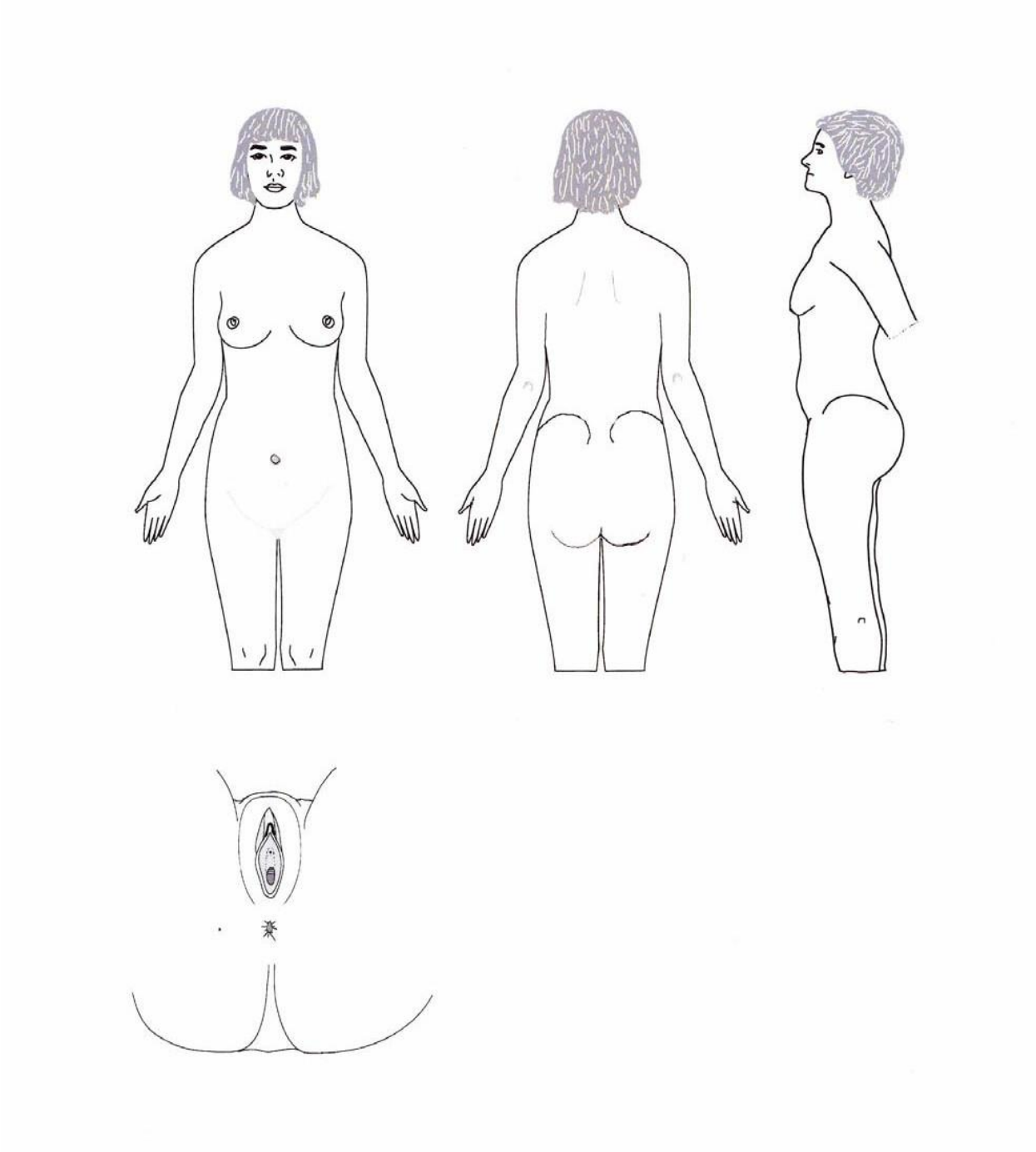
Bladder sensation worksheet: Instructions:

Please indicate the location(s) on the body maps below by placing and "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?



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Patient's Name: _____ Today's date_____

PELVIC PAIN and URGENCY/FREQUENCY 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+		
2	a. How many times do you go to the bathroom at night?	0	1	2	3	4+		
	b. If you get up at night to go to the bathroom, does it bother you?	Never Bothers	Occasionally	Usually	Always			
3	a. Do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always			
	b. Has pain or urgency ever made you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
4	Do you have pain associated with your bladder or in your pelvis (vagina, labia, lower abdomen, urethra, perineum, testes, or scrotum)?	Never	Occasionally	Usually	Always			
5	a. If you have pain, is it usually		Mild	Moderate	Severe			
	b. Does your pain bother you?	Never	Occasionally	Usually	Always			
6	Do you still have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7	a. If you have urgency, is it usually		Mild	Moderate	Severe			
	b. Does your urgency bother you?	Never	Occasionally	Usually	Always			
8	Are you sexually active? Yes No							

SYMPTOM SCORE = (1, 2a, 3a, 4, 5a, 6, 7a)	
BOTHER SCORE = (2b, 3b, 5b, 7b)	
TOTAL SCORE (Symptom Score + Bother Score) =	

Revised 11/17/2003

Pelvic Floor Questionnaire (PFIQ-7)

Instructions:

Some women find that 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 daily life?

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

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

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

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

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

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

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
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

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5. Participating in social activities outside your home?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

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

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

7. Feeling frustrated?

	Not at all	Somewhat	Moderately	Quite a bit
Bladder or urine				
Bowel or rectum				
Vagina or pelvis				

For Clinic Use

			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)

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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.

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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 your daily life?

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.

Always (4)	Usually	Sometimes	Seldom	Never (0)

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

Always (4)	Usually	Sometimes	Seldom	Never (0)

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

Always (4)	Usually	Sometimes	Seldom	Never (0)

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

Always (4)	Usually	Sometimes	Seldom	Never(0)

5. Do you feel pain during sexual intercourse?

Always (0)	Usually	Sometimes	Seldom	Never (4)

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

Always (0)	Usually	Sometimes	Seldom	Never (4)

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

Always (0)	Usually	Sometimes	Seldom	Never(4)

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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)

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)

10. Does *your* partner have a problem with erections that affects your sexual activity?

Always(0)	Usually	Sometimes	Seldom	Never(4)

11. Does your partner have a problem with premature ejaculation that affects your sexual activity?

Always(0)	Usually	Sometimes	Seldom	Never(4)

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)

Sincere thanks for completing this questionnaire prior to your new patient appointment

For Clinic Use Only

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

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