



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

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(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)

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

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>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Continue on back if needed

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Past Medical History

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

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Asthma | <input type="checkbox"/> Uterine cancer |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Ovarian cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood clots (DVT, etc.) | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Pelvic radiation for cancer |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Lupus | <input type="checkbox"/> Bladder cancer |
| <input type="checkbox"/> 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>

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

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> Tubal ligation | Reason and date of surgery: _____ |
| <input type="checkbox"/> Laparoscopy | Reason and date of surgery: _____ |
| <input type="checkbox"/> Exploratory laparotomy | Reason and date of surgery: _____ |
| <input type="checkbox"/> Vaginal suspension | Reason and date of surgery: _____ |
| <input type="checkbox"/> Cystocele repair | Reason and date of surgery: _____ |
| <input type="checkbox"/> Rectocele repair | Reason and date of surgery: _____ |
| <input type="checkbox"/> Bladder tack | Reason and date of surgery: _____ |
| <input type="checkbox"/> Incontinence surgery | |
| <input type="checkbox"/> Suburethral Sling | Reason and date of surgery: _____ |
| <input type="checkbox"/> Burch | Reason and date of surgery: _____ |
| <input type="checkbox"/> MMK | Reason and date of surgery: _____ |
| <input type="checkbox"/> Collagen | Reason and date of surgery: _____ |
| <input type="checkbox"/> Other Abdominal surgeries | |
| <input type="checkbox"/> Appendectomy | Reason and date of surgery: _____ |
| <input type="checkbox"/> Gallbladder removal | Reason and date of surgery: _____ |
| <input type="checkbox"/> Bowel surgery | Reason and date of surgery: _____ |

<u>Other Surgeries or Hospitalizations (Please list)</u>	<u>Date</u>	<u>Hospital</u>

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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	<input type="checkbox"/> No <input type="checkbox"/> Yes
2	___/___/___	_____	M / F	_____ weeks / months	Vaginal / C/section / Vacuum / Forceps	<input type="checkbox"/> No <input type="checkbox"/> Yes
3	___/___/___	_____	M / F	_____ weeks / months	Vaginal / C/section / Vacuum / Forceps	<input type="checkbox"/> No <input type="checkbox"/> Yes
4	___/___/___	_____	M / F	_____ weeks / months	Vaginal / C/section / Vacuum / Forceps	<input type="checkbox"/> No <input type="checkbox"/> Yes
5	___/___/___	_____	M / F	_____ weeks / months	Vaginal / C/section / Vacuum / Forceps	<input type="checkbox"/> No <input type="checkbox"/> Yes
6	___/___/___	_____	M / F	_____ weeks / months	Vaginal / C/section / Vacuum / Forceps	<input type="checkbox"/> No <input type="checkbox"/> Yes

(Continue on back if needed)

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

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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: ____/____/____

1	Do you usually experience pressure in the lower abdomen?	No 0	Yes	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 heaviness or dullness in the pelvic area?	No 0	Yes	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	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	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	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	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	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	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	If other than never, 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	If other than never, how much does this bother you?	Not at all 1	Somewhat 2	Moderately 3	Quite a bit 4

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

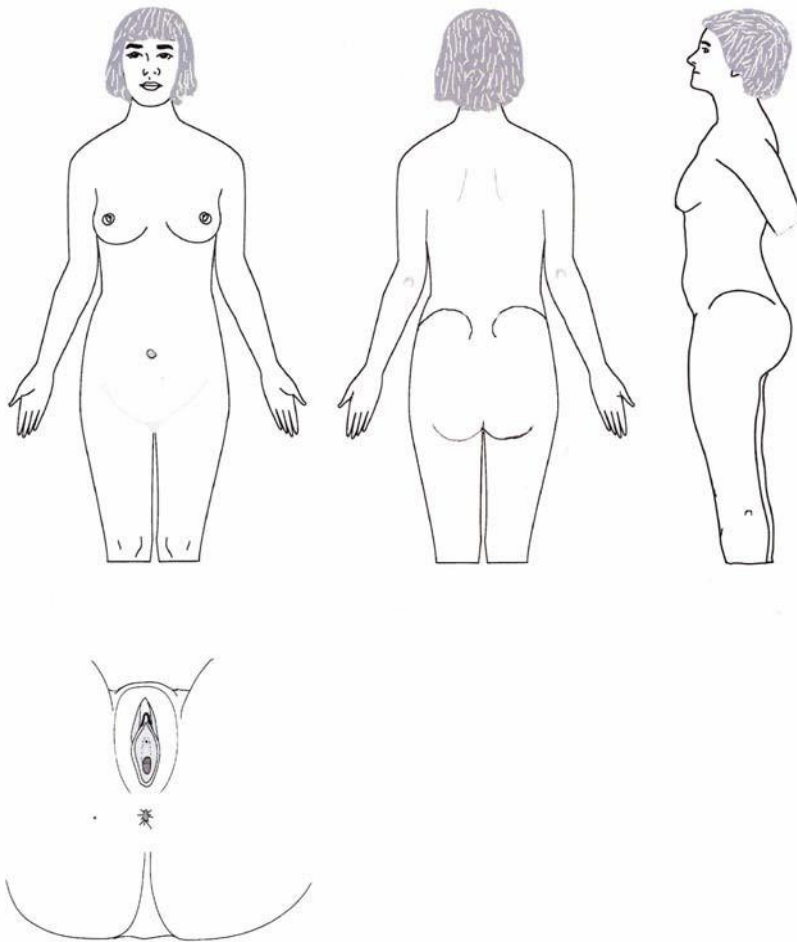
Pain level (please circle) 0 - no pain 1 2 3 4 5 6 7 8 9 10 – worst pain of my life

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"

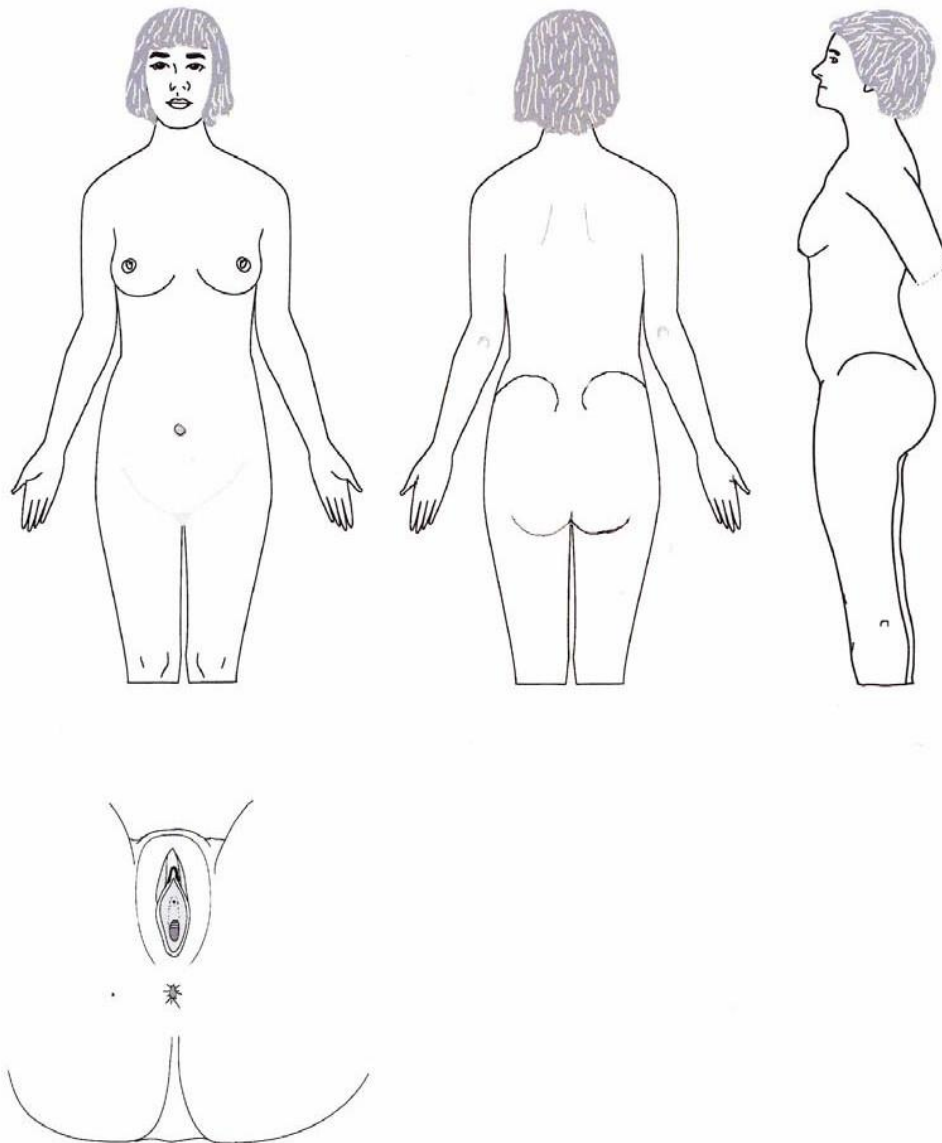
Please mark the location with an "X" or "O" on the images below.



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?



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) =		

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
<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"/>

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5. Participating in social activities outside your home?

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

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

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

7. Feeling frustrated?

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

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

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.

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?

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.

1. 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)
	<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"/>

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

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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