Mikio Nihira, MD
Lieschen Quiroz, MD
Abbas Shobeiri, MD (Director)

WOMEN'S PELVIC &
BLADDER HEALTH
Female Pelvic Medicine & Reconstructive Surgery

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 our website at www.urogynecologist.com You may also be interested to visit the website of the *American Urogynecological 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 3rd floor of the OU Physicians Building, 825 NE 10th, suite 3400, Oklahoma City. 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
- 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.

After your nursing assessment, one of the doctors will review 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.

After we have 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.

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Please keep in mind that OU 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.
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.
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 examination and answer questions about your diagnosis and treatment plan.

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.

Your referring physician will be sent a letter documenting your care after your visit, usually within 5 business days. 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. We are proud of the fact that incorporating our patients' suggestions into our practice has resulted in OU Women's Pelvic and Bladder Health Clinic having one of the highest patient and employee satisfaction scores amongst OU medical practices. 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.

Sincerely,

S. Abbas Shobeiri, MD　　Lieschen H. Quiroz, MD　　Mikio A. Nihira, MD, MPH

www.urogynecologist.com
825 N.E. 10th Suite 3400, Oklahoma City, OK 73104
Appointments: (405) 271-9493, fax: (405) 271-4606

WOMEN'S PELVIC &
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Female Pelvic Medicine & Reconstructive Surgery

Mikio Nihira, MD
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UROGYNECOLOGY INTAKE FORM

DEAR PATIENT:

This is a questionnaire pertaining to your general information and physical complaints. Completing the following questionnaire should take 10 minutes of your time. Please complete this questionnaire prior to your arrival at our office. If needed, you can seek the help of a family member or a friend to complete this Questionnaire.

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:

____
____
____
____
____
____
____
____

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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 fluid 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

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Gynecologic

14. Do you feel that your bladder, uterus, vagina or rectum is 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)

Medication	Reaction	Medication	Reaction

F. Medications

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

Medication name	Dose	Frequency	Prescribing Physician

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G. 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
____________________	____________	____________
____________________	____________	____________
____________________	____________	____________
____________________	____________	____________

H. Past Surgical History

(Please list any previous surgeries/operations)

☐ **Hysterectomy** Date of operation:____________________

Please check the type of hysterectomy

☐ Abdominal hysterectomy ☐ Vaginal hysterectomy ☐ Supracervical hysterectomy ☐ Laparoscopic

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

Reason for surgery:____

Any other procedures performed during surgery:____

☐ **Other Gynecologic surgeries**

☐ Removal of ovaries (separate from the time of hysterectomy) Date of operation:______________________

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

Reason for surgery:____

Any other procedures performed during surgery:____

☐ Tubal ligation	Reason and date of surgery:____________________
☐ Laparoscopy	Reason and date of surgery:____________________
☐ Exploratory laparotomy	Reason and date of surgery:____________________
☐ Other Abdominal surgeries	Reason and date of surgery:____________________
☐ Appendectomy	Reason and date of surgery:____________________
☐ Gallbladder removal	Reason and date of surgery:____________________
☐ Bowel surgery	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:____________________

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Incontinence surgery

- ☐ 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 Surgeries or Hospitalizations (Please list)	Date	Hospital

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 ---------

J. Gynecologic History

Menstrual History

Date of 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:_______________________________

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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

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UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER
Dept. OB/GYN, Section of Female Pelvic Medicine & Reconstructive Surgery
UROGYNECOLOGY QUESTIONNAIRE (FOR PATIENTS WHOSE PRIMARY COMPLAINT IS NOT PAIN)

Name ____ Date______________
Date of Birth _____________________
ID # ____________________________
Evaluated by ____

DEAR PATIENT:
This is a questionnaire pertaining to your pelvic health. Completing the following questionnaire should take 10 minutes of your time. Please complete this questionnaire prior to your arrival at our office. If needed, you can seek the help of a family member or a friend to complete this Questionnaire.

Pelvic Floor Questionnaire (PFDI-20)

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.

		No	Yes		Not at all	Somewhat	Moderately	Quite a bit
1	Do you usually experience *pressure* in the lower abdomen?	0		If yes, how much does this bother you?	1	2	3	4
2	Do you usually experience *heaviness* Or *dullness* in the pelvic area?	0		If yes, how much does this bother you?	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		If yes, how much does this bother you?	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		If yes, how much does this bother you?	1	2	3	4
5	Do you usually experience a feeling of incomplete bladder emptying?	0		If yes, how much does this bother you?	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		If yes, how much does this bother you?	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 yes, 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 yes, how much does this bother you?	1	2	3	4

	Question	No	Yes		Not at all	Somewhat	Moderately	Quite a bit
11	Do you usually lose gas from the rectum beyond your control?	0		If yes, how much does this bother you?	1	2	3	4
12	Do you usually have pain when you pass your stool?	0		If yes, how much does this bother you?	1	2	3	4
13	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
14	Does a part of your bowel every pass through the rectum and bulge outside during or after a bowel movement?	0		If yes, how much does this bother you?	1	2	3	4

	Question	No	Yes		Not at all	Somewhat	Moderately	Quite a bit
15	Do you usually experience frequent urination?	0		If yes, how much does this bother you?	1	2	3	4
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?	0		If yes, how much does this bother you?	1	2	3	4
17	Do you usually experience urine leakage related to coughing, sneezing, or laughing?	0		If yes, how much does this bother you?	1	2	3	4
18	Do you usually experience small amounts of urine leakage (that is, drops)?	0		If yes, how much does this bother you?	1	2	3	4
19	Do you usually experience difficulty emptying your bladder?	0		If yes, how much does this bother you?	1	2	3	4
20	Do you usually experience *pain* or *discomfort* in the lower abdomen or genital region?	0		If yes, how much does this bother you?	1	2	3	4

ID # ________________________ DATE: ____________________

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?

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				

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				

ID # _________________________ DATE: _____________________

6. Emotional health (nervouseness, 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				

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?

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 you 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)

Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum or vagina falling our?)?

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)

FOR PHYSICIAN ENTRY:

____

____

____

____

____

____

____

____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.

UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

Dept. OB/GYN, Section of Female Pelvic Medicine & Reconstructive Surgery

UROGYNECOLOGY PAIN QUESTIONNAIRE (ONLY COMPLETE IF YOU HAVE PELVIC PAIN)

Name ____ Date______________

Date of Birth _____________________

ID # ___________________________

Evaluated by ____

DEAR PATIENT:

This is a questionnaire pertaining to your pelvic health. Completing the following questionnaire should take about 15 minutes of your time. Please complete this questionnaire prior to your arrival at our office. If needed, you can seek the help of a family member or a friend to complete this Questionnaire.

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.

#	Question	No	Yes		Not at all	Somewhat	Moderately	Quite a bit
1	Do you usually experience *pressure* in the lower abdomen?	0		If yes, how much does this bother you?	1	2	3	4
2	Do you usually experience *heaviness* Or *dullness* in the pelvic area?	0		If yes, how much does this bother you?	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		If yes, how much does this bother you?	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		If yes, how much does this bother you?	1	2	3	4
5	Do you usually experience a feeling of incomplete bladder emptying?	0		If yes, how much does this bother you?	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		If yes, how much does this bother you?	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 yes, 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 yes, how much does this bother you?	1	2	3	4

ID # ________________________ DATE: ____________________

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?

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				

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				

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

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

7. Feeling frustrated?

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

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?

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 you 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)

Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum or vagina falling our?)?

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)

***** ONE MORE QUESTIONNAIRE ON THE NEXT PAGE *****

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Information About Your Pain

Please describe your pain problem: ____

What do you think is causing your pain? ____

What does your family think is causing your pain? ____

Do you think anyone is to blame for your pain? ☐Yes ☐No If so, what? ______________________________

Do you think surgery will be necessary? ☐Yes ☐No

Is there an event that you associate with the onset of pain? ☐Yes ☐No If so, what? ____________________

How long have you had this pain? ☐ <6 months ☐ 6 months-1 year ☐ 1-2 years ☐ >2 years

For each of the symptoms listed below, please "bubble in" your level of pain over the last month using a 10-point scale:

0 – no pain 10 – the worst pain imaginable

How would you rate your present pain?	0	1	2	3	4	5	6	7	8	9	10
Pain at ovulation (mid-cycle)	o	o	o	o	o	o	o	o	o	o	o
Pain level just before period	o	o	o	o	o	o	o	o	o	o	o
Pain (not cramps) with period	o	o	o	o	o	o	o	o	o	o	o
Deep pain with intercourse	o	o	o	o	o	o	o	o	o	o	o
Pain in groin when lifting	o	o	o	o	o	o	o	o	o	o	o
Pelvic pain lasting hours or days after intercourse	o	o	o	o	o	o	o	o	o	o	o
Pain when bladder is full	o	o	o	o	o	o	o	o	o	o	o
Muscle/joint pain	o	o	o	o	o	o	o	o	o	o	o
Ovarian pain	o	o	o	o	o	o	o	o	o	o	o
Level of cramps with period	o	o	o	o	o	o	o	o	o	o	o
Pain after period is over	o	o	o	o	o	o	o	o	o	o	o
Burning vaginal pain with sex	o	o	o	o	o	o	o	o	o	o	o
Pain with urination	o	o	o	o	o	o	o	o	o	o	o
Backache	o	o	o	o	o	o	o	o	o	o	o
Migraine headache	o	o	o	o	o	o	o	o	o	o	o
What would be an acceptable level of pain?	o	o	o	o	o	o	o	o	o	o	o

What is the worst type of pain that you have ever experienced?

☐ Kidney stone ☐ Bowel obstruction ☐ Migraine headache

☐ Labor & delivery ☐ Current pelvic pain ☐ Backache

☐ Broken bone ☐ Surgery

☐ Other ____

Who are the people you talk to concerning your pain, or during stressful times?

☐ Spouse/partner ☐ Relative ☐ Support Group ☐ Clergy

☐ Friend ☐ Doctor/Nurse ☐ Mental Health Professional ☐ I take care of myself

How does your partner deal with your pain?

☐ Doesn't notice when I'm in pain ☐ Takes care of me ☐ Not applicable

☐ Withdraws ☐ Feels helpless

☐ Distracts me with activities ☐ Gets angry

What helps your pain?

☐ Meditation ☐ Relaxation ☐ Lying down ☐ Music

☐ Massage ☐ Ice ☐ Heating pad ☐ Hot bath

☐ Pain medication ☐ Laxatives/enema ☐ Injection ☐ TENS unit

☐ Bowel movement ☐ Emptying bladder ☐ Nothing

☐ Other ____

ID # ___________________________ DATE: ______________________

What makes your pain worse?
☐ Intercourse ☐ Orgasm ☐ Stress ☐ Full meal
☐ Bowel movement ☐ Full bladder ☐ Urination ☐ Standing
☐ Walking ☐ Exercise ☐ Time of day ☐ Weather
☐ Contact with clothing ☐ Coughing/sneezing ☐ Not related to anything
☐ Other ____

Of all of the problems or stresses in your life, how does your pain compare in importance?
☐ The most important problem ☐ Just one of several/many problems

Short-Form McGill

The words below describe average pain. Place a check mark (√) in the column which represents the degree to which you feel that type of pain. Please limit yourself to a description of the pain in your pelvic area only.

What does your pain feel like?

Type	***None (0)***	***Mild (1)***	***Moderate (2)***	***Severe (3)***
Throbbing				
Shooting				
Stabbing				
Sharp				
Cramping				
Gnawing				
Hot-burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring-Exhausting				
Sickening				
Fearful				
Punishing-Cruel				

Melzack, R: The Short-Form McGill Pain Questionnaire, Pain 30:191-197, 1987

SF-36

In general, would you say your health is? o Excellent o Very Good o Good o Fair o Poor

Compared to one year ago, how would you rate your health in general now?
- o Much better now than one year ago
- o Somewhat better now than one year ago
- o About the same as one year ago
- o Somewhat worse now than one year ago
- o Much worse than one year ago

The following items are about activities you might do during a typical day. *Does your health now limit you in these activities? If so, how much?*	Yes, limited A lot	Yes, limited a little	No	Not limited At all
Vigorous activities, such as running, lifting heavy object, participating in strenuous sports				
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf				
Lifting or carrying groceries				
Climbing several flights of stairs				
Climbing one flight of stairs				
Bending, kneeling, or stooping				
Walking more than a mile				
Walking several blocks				
Walking one block				
Bathing or dressing yourself				

What would you like to tell us about your pain that we have not asked? Comments:

____

____

____

ID # ___________________________ Date:___________________________

What types of treatments have you tried in the past for this pain?

- □ Acupuncture
- □ Anesthesiologist
- □ Anti-seizure medications
- □ Antidepressants
- □ Biofeedback
- □ Birth control pills
- □ Danazol (Danocrine)
- □ Depo-Provera
- □ Family Practitioner
- □ Herbal medication
- □ Homeopathic medicine
- □ Lupron, Zoladex, Synarel
- □ Massage
- □ Meditation
- □ Narcotics
- □ Naturopathic medications
- □ Nerve blocks
- □ Neurosurgeon
- □ Nonprescription medicine
- □ Nutrition/diet
- □ Physical therapy
- □ Psychotherapy
- □ Rheumatologist
- □ Skin magnets
- □ Surgery
- □ TENS unit
- □ Trigger point injections
- □ Other ____________________

What physicians or health care providers have evaluated or treated you for chronic pelvic pain? Include all healthcare professionals, whether they were physicians or not. Do you have any objections to me contacting these healthcare providers? □ Yes □ No

Physician/Provider	*City, State*

FOR PHYSICIAN ENTRY:

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THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.