NorthShore University HealthSystem
Urogynecology & Pelvic Health Centers

Phone: 847-570-2750 Fax: 847-570-1386

Evanston Office	**Vernon Hills Office**	**Skokie Office**
1000 Central Street	225 N. Milwaukee Ave	9700 N Kenton Ave
Suite 730	Specialty Suites	Suite 100
Evanston, IL 60201	Vernon Hills, IL 60061	Skokie, IL 60076
Highland Park Office	**Glenbrook Office**	**Gurnee Office**
757 Park Avenue West	2050 Pfingsten Road	15 Tower Court
Suite 3870	Suite 128	Suite 300
Highland Park, IL 60035	Glenbrook, IL 60025	Gurnee, IL 60031
Dr. Roger Goldberg	Dr. Sylvia Botros	Time:
Dr. Peter Sand	Dr. Janet Tomezsko	Date:

Before You Arrive

Prior to your appointment date it is necessary for you to call our **Pre-Registration Department at 847-663-8600 to verify your insurance.**

Please complete the enclosed forms in order to help us provide you with the best possible care. **It is important that you bring these COMPLETED forms with you on your first visit.** Please arrive 15 minutes PRIOR to your scheduled appointment time to complete additional paperwork.

Included in this packet are the following questionnaires:

1. **Medical History Questionnaire:** A detailed assessment of symptoms and health conditions.
2. **Pelvic Floor Questionnaire & Sexual Function Questionnaire**
3. **Voiding Diary:** Necessary to complete if you have issues involving bladder control, or urinary symptoms, as it provides a record of your urinary pattern over a 24-hour period.

Please Keep in Mind

1. ***Full Bladder**: Please come to your first visit with a partially full bladder, as we may do a voiding study/testing (such as uroflowmetry) at that time. Let the receptionists know if you are uncomfortable on arrival.
2. **Initial Examination**: A comprehensive urogynecologic exam is usually performed on the first visit. If indicated other bladder testing will also be performed (ie urine culture, post-void residual).
3. **Canceling or Rescheduling**: In the event you need to cancel or reschedule your appointment, at any office site, please call 847-570-2750, as soon as possible.
4. **Late Arrival**: In the event you may be late, please call 847-570-2750 and let the office know. We cannot guarantee your visit if you arrive more than 15 minutes late.
5. **Billing Policy**: All billing is handled by the Professional Business Office at NorthShore University HealthSystem. If your insurer requires a co-payment, you will be required to pay this at the time of service. Our office will submit all billing information to the billing office where your claim will be filed. For billing or insurance questions, please contact the billing office at (877) 210-4351 between 8am - 4pm.
6. **NorthShore Connect**: Allows for convenient and efficient e-mail communication between you and the nurses and doctors at our office, and also provides you with computer access to test results and other information. If you're not already enrolled in NorthShore Connect, please ask the receptionist for login instructions.

About Our Center

Over the past few decades, our center has established itself as an internationally recognized center of excellence in Urogynecology and Female Pelvic Medicine and Reconstructive Surgery – a specialty devoted to female bladder, bowel and pelvic floor conditions.

Our highest priority is to provide you with the most advanced care, in a comfortable and efficient way. We believe that approaching these problems in a comprehensive fashion with a group of specialized nurses and physicians offers the best way to treat your problem. Our commitment to research and innovation allows our patients access to the 'cutting edge' of our field, including the latest medications in development and the most recent surgical innovations. We welcome your comments and feedback, as we strive to provide the very best care for these female conditions.

We are also a nationally recognized fellowship training center in our subspecialty of Female Pelvic Medicine and Reconstructive Surgery. The fellows will be an integral part of your care as they assist the attending physicians. The fellows usually will see you along with the attending physician at your first office visit, and often for follow-up visits and office testing.

Our Urogynecologists

Peter Sand, MD – Dr. Sand received his Bachelor of Science and Medical Degree at Northwestern University. He took his residency in Obstetrics and Gynecology at Northwestern University and completed a Fellowship in Urogynecology and Pelvic Surgery at the University of California, Irvine. Dr. Sand founded this division and center in 1991, and has directed the Fellowship program. He is a Clinical Professor of Obstetrics and Gynecology at the University of Chicago, Pritzker School of Medicine. Dr. Sand is the recipient of numerous prestigious awards, and has served as President of the International Urogynecologic Association and Associate Editor of the International Urogynecology Journal.

Roger Goldberg, MD MPH - Dr. Goldberg completed his Bachelor of Arts at Cornell University and attended Northwestern University Medical School. He received his Masters in Public Health at Johns Hopkins University prior to his residency in Ob/Gyn at Harvard University's Beth Israel Hospital. Dr. Goldberg is the Director of Urogynecology Research, and Associate Clinical Professor of Ob/Gyn, University of Chicago. He has received awards from the Society of Gynecologic Surgeons, American College of Obstetricians and Gynecologists, International Continence Society and International Urogynecology Association (IUGA). Dr. Goldberg is the author of numerous articles and two books on Urogynecology and pelvic floor disorders.

Sylvia Botros, MD – Dr. Botros received her medical degree from The University of Texas Health Science Center and completed her residency in Obstetrics and Gynecology at the Lyndon B Johnson Hospital in Houston, TX. She completed her fellowship program in Urogynecology and Pelvic Reconstructive Surgery at Northwestern University, Feinberg School of Medicine, during which she has authored several scientific publications and presented at numerous national and international meetings. Dr. Botros has also received a Masters degree in Clinical Investigation from Northwestern University School of Public Health.

Janet Tomezsko, MD – Dr. Tomezsko completed her Bachelor of Science at Penn State University before attending Hahnemann University in Philadelphia, PA. She completed her residency training in Obstetrics and Gynecology at Lehigh Valley Hospital in Allentown, PA. She completed her fellowship in Urogynecology at Northwestern University in 1997. Dr. Tomezsko was Chief of Urogynecology at Northwestern Medical Faculty Foundation until joining NorthShore Urogynecology in 2009. Dr. Tomezsko has published several scientific articles, and has given many lectures throughout the country in the field of urogynecology.

Karen Sasso, RN, APN – Karen is a Clinical Nurse Specialist who provides expertise in the areas of urodynamics testing, electrical stimulation and biofeedback. She has been with the center since 1991 and sees patients independently for testing, treatments, and follow-up.

Urogynecology Fellows – Our care team includes three fellows in Urogynecology and Reconstructive Pelvic Surgery. Each of these physicians has completed his/her residency in Obstetrics and Gynecology, and is devoting an additional 3 years to subspecialty training within our division. It is likely that a fellow will be involved as an assistant with your care in the office, and also in the hospital if you choose to undergo surgery.

NorthShore University HealthSystem Urogynecology:
Initial Visit Questionnaire

Name ________________________ **Date of birth:** _________________**Date** ___________________

PLEASE PROVIDE THE NAME, ADDRESS, AND OFFICE NUMBER OF YOUR PRIMARY CARE PHYSICIAN AND YOUR GYNECOLOGIST:

PCP:
Name ______________________
Address ______________________
____
Phone ______________________
Fax ______________________

GYNECOLOGIST:
Name ______________________
Address ______________________
____
Phone ______________________
Fax ______________________

***** Which of the above physicians referred you to our office?*** ________________________

Please describe 'in your own words' the nature of your gynecologic or urologic problems.
____
____
____
____

What are the main reasons for your visit?
*****(please check all that apply, and underline the one problem that bothers you the most)

Urinary leakage with cough/sneeze/exercise
Urinary leakage when you feel the need to get to the bathroom
Frequent urination
Frequent urination at night
Bladder infections
Unable to empty bladder
Vaginal bulging -- dropped bladder/uterus/rectum
Pelvic pain
Vaginal or vulvar pain
Painful urination
Interstitial cystitis
Constipation, or other difficulties having bowel movements
Loss of bowel control

Other (please describe) ____
How long has this problem bothered you?____
What treatments or evaluations have you had in the past for this problem? ________________
____
What is your main goal in seeking help for this problem?
____
____

During an average day, how often do you urinate? ____________________

During an average night, how often do you get up to urinate? ____________________

During an average day, how many pads or diapers do you use? ____________________

How often do you experience urine leakage (incontinence)?

0 - never
1 - less than once a month?
2 - one or several times a month
3 - one or several times a week
4 - every day/night

How much urine do you lose each time?

1 - drops/little
2 - more

ALLERGIES

Do you have any drug allergies? Y N

Please list which drugs you are allergic to and what happens when you take them.

____

____

MEDICAL HISTORY

As a Child did you have:

Bladder infections Kidney infections Other ______________________

As an Adult have you had (please circle):

Heart Disease	Reflux / GERD	Depression
High Blood Pressure	Liver Disease	Serious Injury / Accident
Diabetes	Stomach / Duodenal Ulcers	Paralysis
Anemia	Kidney Disease	Back Problems
Thyroid Disease	Frequent Bladder Infections	Glaucoma
Blood Clots	Kidney / Bladder Stones	Anxiety disorder
Stroke	Multiple Sclerosis	Parkinson's Disease
Chronic Cough / Asthma	Psychiatric Illness	Gonorrhea
Pneumonia	Seizure Disorder	HIV
Gonorrhea	Chlamydia	Herpes
Venereal warts	Abnormal Pap Smears	Syphilis

Cancer: *If yes, what type* ___________________ *What type of treatment*_______________

Other ____

SURGICAL HISTORY

Have you had a Hysterectomy? Yes No

If yes: For what reason? ________________

At what age? ________________

What type of incision? Abdominal Vaginal Laparoscopic

Have you had your ovaries removed? Yes No

Have you had any previous surgery for incontinence? Yes No

Type and Date: ____

Have you had any previous surgery for pelvic relaxation / prolapse? Yes No

Type and Date: ____

Please list any other operations you've had, and the year that it was performed:

____

____

____

FAMILY & SOCIAL HISTORY

Have any first degree relatives had these diseases? If so, please indicate their relationship to you.

High Blood Pressure ___________________ Diabetes ___________________________

Stroke _______________________________ Heart Disease _______________________

Cancer (please list type) _______________ Ovarian Cancer: _____________________

Breast Cancer _________________________ Kidney Disease _______________________

Blood / Clotting Disorder________________ Osteoporosis __________________________

Urinary Incontinence ___________________ Relaxation of uterus or vagina ___________

Other Family or Hereditary Diseases ____

Do you smoke: Yes No

If yes … How many packs per day? ______ How many years? _____

Do you drink alcohol: Yes No

If yes … How many drinks per week? ______

Your occupation_________________ Spouse's occupation __________________

Current marital status (circle one): Married Single Divorced Widowed

Number of Pregnancies _____ Number of Children _____

Number of Miscarriages _____ Number of Abortions _____

MEDICATIONS

Please list all current medications (including hormones, contraceptives, vitamins) and dosages:

____

____

____

____

____

SYMPTOM REVIEW: Please circle any symptoms you've had in the past few months:

General Symptoms
Fever or Chills
Headache
Weight loss/gain >10 pounds

Endocrine
Intolerance to hot/cold
Excessive fatigue

Skin
Rash
Easy bruising

Respiratory
Breathing difficulties
Shortness of breath
Wheezing

Neuro / Muscular
Sleepiness or weakness
Dizziness
Weakness

Gastrointestinal
Involuntary loss of stool
Constipation
Diarrhea

Gynecologic
Breast pain or lump
Hot flashes
Vaginal bleeding
Vaginal discharge

Psychiatric
Depression
Worsening moods
Anxiety
Difficulty remembering

Hematologic / Allergy
Clotting problems
Prolonged bleeding

Cardiovascular
Chest discomfort or pain
Shortness of breath with exertion
Swelling of legs

Eyes/Ear/Nose/Throat/ Mouth
Dry mouth
Dry eyes

Patient Name: ____

Date of birth: _______________________________ Date: __________________________

Pelvic Floor Distress Inventory Questionnaire

Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder or pelvic symptoms and if you do how much they bother you. Answer each question by putting an **X** in the appropriate box or boxes. If you are unsure about how to answer, please give the best answer you can. While answering these questions, please consider your symptoms over the **last 3 months**.

		If **YES**, how much does it bother you?			
		Not at all	Somewhat	Moderately	Quite a bit
Do you usually experience pressure in the lower abdomen?	☐ Yes ☐ No	☐	☐	☐	☐
Do you usually experience heaviness or dullness in the lower abdomen?	☐ Yes ☐ No	☐	☐	☐	☐
Do you usually have a buldge or something falling out that you can see or feel in the vagina area?	☐ Yes ☐ No	☐	☐	☐	☐
Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?	☐ Yes ☐ No	☐	☐	☐	☐
Do you usually experience a feeling of incomplete bladder emptying?	☐ Yes ☐ No	☐	☐	☐	☐
Do you ever have to push up in the vaginal area with your fingers to start or complete urination?	☐ Yes ☐ No	☐	☐	☐	☐
Do you feel you need to strain too hard to have a bowel movement?	☐ Yes ☐ No	☐	☐	☐	☐
Do you feel you have not completely emptied your bowels at the end of a bowel movement?	☐ Yes ☐ No	☐	☐	☐	☐
Do you usually lose stool beyond your control if your stool is well formed?	☐ Yes ☐ No	☐	☐	☐	☐
Do you usually lose stool beyond your control if you stool is loose or liquid?	☐ Yes ☐ No	☐	☐	☐	☐
Do you usually lose gas from the rectum beyond your control?	☐ Yes ☐ No	☐	☐	☐	☐
Do you usually have pain when you pass your stool?	☐ Yes ☐ No	☐	☐	☐	☐
Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	☐ Yes ☐ No	☐	☐	☐	☐
Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	☐ Yes ☐ No	☐	☐	☐	☐
Do you usually experience frequent urination?	☐ Yes ☐ No	☐	☐	☐	☐

(See next page)

Pelvic Floor Distress Inventory Questionnaire

If **YES**, how much does it bother you?

		Not at all	Somewhat	Moderately	Quite a bit
Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?	☐ Yes ☐ No	☐	☐	☐	☐
Do you experience urine leakage related to laughing, coughing, or sneezing?	☐ Yes ☐ No	☐	☐	☐	☐
Do you usually experience small amounts of urine leakage (that is, drops)?	☐ Yes ☐ No	☐	☐	☐	☐
Do you usually experience difficulty emptying your bladder?	☐ Yes ☐ No	☐	☐	☐	☐
Do you usually experience pain of discomfort in the lower abdomen or genital region?	☐ Yes ☐ No	☐	☐	☐	☐

Sexual Function Questionnaire (PISQ-12)

The following are questions about you and your partner's sex life. All information is strictly confidential.

a. Have you had sex in the last 6 months? Yes No

If yes, please answer the questions according to your *current experience*.

If no, please answer questions according to the *last year* you were sexually active.

b. If you are <u>not</u> currently sexually active, at what age did you stop activity?______

Why are you not currently sexually active? *(Circle one or more of the following)*

Incontinence	Vaginal prolapse	Fear of incontinence
Bladder pain	Vaginal pain	Burning
Urinary urgency	Lack of desire	Chronic illness
Partner's impotence	Stressful situation at home	Fatigue
Partner's lack of desire	No partner	Lack of privacy

Other____

1. **How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex, feeling frustrated due to lack of sex, etc.**

   ☐ Daily ☐ Weekly ☐ Monthly ☐ less than once a month ☐ Never

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

   ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

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

   ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

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

   ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

5. **Do you feel pain during sexual intercourse?**

   ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

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

   ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

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

   ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

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

   ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

9. **When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?**

   ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

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

    ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

11. **Does your partner have a problem with <u>premature ejaculation</u> that affects your sexual activity?**

    ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

12. **Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?**

    ☐ Much less intense ☐ Less intense ☐ Same intensity ☐ More Intense ☐ Much more intense

Voiding Diary Instructions

Please complete the following diary <u>if you have any of the following problems</u>:

- ***Urinary leakage ('incontinence')***
- ***Frequent urination***
- ***Frequent nighttime voiding***
- ***Sudden urges to urinate***

INSTRUCTIONS:

The chart printed on the next page will allow you to provide a record of your voiding (urinating) and leakage (incontinence) of urine.

Please choose a 24 hour period to keep this record when you can conveniently measure your voids. If you are unable to keep the diary for a 24-hour period, try to keep it for as many hours as possible, say from early evening when you get home from work until you get up the next morning.

Record the time of all voiding, leakage, and intake of liquids. Include all voids, even if they occur in the middle of the night.

Measure all intake and output in ounces or mL (30 mL = 1 oz) (1 cup = 8 oz = 240 mL). You can use a standard 1-cup measuring device and label your volumes in ounces or milliliters. You may, of course, discard the measured urine after each void. Describe activity you were performing at the time of leakage. If you were not actively doing anything, record whether you were sitting, standing, or lying down.

Estimate the amount of leakage according to the following scale:

0 = no leakage
1 = damp, few drops only
2 = wet underwear or pad
3 = soaked or emptied bladder

If the urge to urinate accompanied (or preceded) the urine leakage, write "Yes".
If you felt no urge when the leakage occurred, write "No".

EXAMPLE:

TIME	AMOUNT VOIDED	ACTIVITY	LEAK VOLUME	URGE PRESENT	AMOUNT/TYPE OF INTAKE
6:45 am	*10 oz*	*Awakening*			
7:00 pm		*Washing Dishes*	*2*	*Yes*	*1 cup coffee* *½ glass water*

VOIDING DIARY

TIME	AMOUNT VOIDED	ACTIVITY	LEAK VOLUME (Circle)	URGE PRESENT (Circle)	AMOUNT/ TYPE OF INTAKE
			0 1 2 3	Yes / No	
			0 1 2 3	Yes / No	
			0 1 2 3	Yes / No	
			0 1 2 3	Yes / No	
			0 1 2 3	Yes / No	
			0 1 2 3	Yes / No	
			0 1 2 3	Yes / No	
			0 1 2 3	Yes / No	
			0 1 2 3	Yes / No	
			0 1 2 3	Yes / No	
			0 1 2 3	Yes / No	
			0 1 2 3	Yes / No	
			0 1 2 3	Yes / No	
			0 1 2 3	Yes / No	
			0 1 2 3	Yes / No	
			0 1 2 3	Yes / No	
			0 1 2 3	Yes / No	
			0 1 2 3	Yes / No	
			0 1 2 3	Yes / No	