# NorthShore University HealthSystem
## Urogynecology & Center for Pelvic Health

**Phone: (224) 251-2374 Fax: (847) 933-3571**

www.northshore.org/pelvic-health/

**Skokie ACC**
9650 Gross Point Road
Suite 3900
Skokie, IL 60076

**Highland Park ACC**
757 Park Avenue West
Suite 3870
Highland Park, IL 60035

**Vernon Specialty Suites**
225 N. Milwaukee Ave
Specialty Suites
Vernon Hills, IL 60061

**Glenbrook Specialty Suites**
2050 Pfingsten Road
Suite 128
Glenview, IL 60025

**Gurnee Medical Office**
15 Tower Court
Suite 300
Gurnee, IL 60031

**Time:**

**Date:**

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**Before You Arrive**

- Prior to your appointment please call Pre-Registration at (847) 663-8600 to verify your insurance
- Please complete the enclosed medical history and symptom forms, to help us provide you with the best possible care.
- BRING THESE COMPLETED forms (and your insurance cards) with you on your first visit.
- Please arrive 15 minutes PRIOR to your appointment to complete additional paperwork
- It is your responsibility to verify with your insurance company and/or PCP if a referral is required. If a referral is required we MUST have it prior to your visit with the doctor. If a referral is required and we do not have one on file, your insurance company may deny coverage for the services rendered. You can have your insurance company and/or PCP fax the referral prior to your appointment to 847-933-3571.

**Please Keep in Mind:**

- **Come to your first visit with a Partially Full Bladder**: Let the receptionists know if you are uncomfortable on arrival.
- **A pelvic examination is usually performed on the first visit.** If indicated other bladder testing may also be performed (e.g. urine culture, post-void residual).
- **Canceling or Rescheduling**: In the event you need to cancel or reschedule your appointment, please notify our office via NorthShore Connect or call (224) 251-2374 (CFPH), as soon as possible.
- **Late Arrival**: In the event you may be late, please call (224) 251-2374 (CFPH) and let the office know. We cannot guarantee your visit if you arrive more than 15 minutes late.
- **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. For billing or insurance questions, please contact the billing office: (847) 570-5000
- **NorthShore Connect**: Allows you to communicate with our office via email, and provides you with computer access to your test results, appointment booking and reminders, and many other benefits. If you have a computer and/or smartphone and are not already enrolled in NorthShore Connect, please visit www.northshoreconnect.org and sign-up or ask the receptionist for login instructions at your visit.

**NorthShore University HealthSystem: Urogynecology Initial Visit Questionnaire**

**Name:** _____ **Date of Birth:** _____

**Your Primary Care Physician:**

Name _____
Address _____
_____
Fax _____

**Your Gynecologist:**

Name _____
Address _____
_____
Fax _____

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

**Which of the following symptoms are bothering you? Check all that apply:**

**URINARY**

- □ Urinary incontinence
- □ Frequent urination
- □ Nighttime voiding
- □ Urgency to urinate
- □ Urinary burning / pain
- □ Frequent bladder infections
- □ Difficulty emptying bladder
- □ Blood in the urine

**VAGINAL**

- □ Vaginal /uterine prolapse (bulge)
- □ Vaginal or vulvar pain
- □ Vaginal bleeding
- □ Vaginal discharge
- □ Vaginal dryness
- □ Vaginal or vulvar itching

**BOWEL**

- □ Accidents involving stool
- □ Accidents involving gas
- □ Constipation

**SEXUAL**

- □ Decreased satisfaction
- □ Painful intercourse

**OTHER**

- □ Pelvic pain
- □ Bladder pain
- □ Rectal pain
- □ Abdominal pain
- □ Back pain

**Other problem not listed above:** _____

**Please list the ONE symptom that is MOST bothersome:** _____

**How long have these problems been present?**

- □ Less than 1 month
- □ 1-6 months
- □ 6-12 months
- □ 1-2 years
- □ 3-5 years
- □ 6-10 years
- □ More than 10 years

**Have you had any prior treatments for these problem(s)?**

- □ No prior treatments
- □ Overactive bladder medication
- □ Antibiotics for frequent bladder infections
- □ Kegel exercises
- □ Physical therapy for the pelvic floor
- □ Vaginal Estrogen Therapy
- □ Surgery for urinary incontinence
- □ Surgery for prolapse (vaginal bulge)
- □ Medication for pelvic or vaginal pain
- □ Pessary
- □ Stool Softeners
- □ Laxatives
- □ Botox (for bladder or pelvic symptoms)
- □ Interstim (“bladder pacemaker”)
- □ Acupuncture (bladder or pelvic symptoms)
- □ Urethral injections
- □ Bladder installations (medicine put into the bladder)
- □ Other: _____

**What are your goals in seeking our help (check all that apply)?**

- □ Improve my bladder control
- □ Decrease daytime urination
- □ Decrease nighttime urination
- □ Reduce urinary (bladder) infections
- □ Fix my prolapse (vaginal "bulge")
- □ Reduce my vaginal prolapse symptoms
- □ Improve my bowel control
- □ Reduce constipation and difficulty having BM's
- □ Improve sexual function
- □ Reduce pain in pelvis, bladder, vagina
- □ Other: _____

**How often are you urinating (# hours between daytime voids)?**

- □ Less than 1 hour
- □ 1
- □ 2
- □ 3
- □ 4
- □ 5
- □ more than 5 hours

**How many times do you wake at night to urinate?**

- □ 0
- □ 1
- □ 2
- □ 3
- □ 4
- □ 5
- □ More than 5 times

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

□ 0 □ 1-2 □ 3-4 □ >5

**How often do you leak urine?**

- □ Never
- □ About once a week or less often
- □ 2-3 times a week
- □ About once a day
- □ Several times a day
- □ All the time

**How much urine do you usually leak? (whether you wear protection or not)**

- □ None
- □ A small amount
- □ A moderate amount
- □ A large amount

**Overall, how much does leaking urine interfere with your everyday life? Please circle a number between 0 (not at all) and 10 (a great deal):**

0 1 2 3 4 5 6 7 8 9 10

*Not at all* *A great deal*

**When does the urine leak? (Please check all that apply)**

- □ Never – urine does not leak
- □ Leaks before you can get to the toilet
- □ Leaks when you cough or sneeze
- □ Leaks when you are asleep
- □ Leaks when you are physically active / exercising
- □ Leaks when you stand up after urinating
- □ Leaks for no obvious reason
- □ Leaks all the time

**Check the one category that best describes how your urinary symptoms are now:**

□ Normal □ Mild □ Moderate □ Severe

**MEDICAL HISTORY**

**As an adult have you had any of the following (check all that apply)?**

- □ Glaucoma
- □ Kidney Disease
- □ Depression
- □ Liver Disease
- □ Anxiety
- □ Back Problems
- □ Fibromyalgia
- □ Breast Cancer
- □ Lung Problems
- □ Blood Clots
- □ Heart Disease
- □ High Blood pressure
- □ Blood in the urine
- □ Bladder Infections
- □ Pelvic Pain
- □ Fibroids
- □ Abnormal Pap Smear
- □ Interstitial Cystitis
- □ Kidney or Bladder Stones
- □ Endometriosis
- □ Recurrent urinary infections
- □ Painful Periods
- □ Postmenopausal Bleeding
- □ Anal Incontinence
- □ Constipation
- □ Irritable Bowel Syndrome (IBS)
- □ Diarrhea
- □ Stroke
- □ Dementia
- □ Multiple Sclerosis
- □ Spinal Stenosis
- □ Parkinson's Disease
- □ Any other medical conditions not listed above? Please list here:

_____

_____

**OBSTETRICAL HISTORY**

Number of Pregnancies _____

Number of Live Births _____

Number of Vaginal Deliveries _____

Number of Cesarean Sections _____

**SURGICAL HISTORY**

**If you're over age 50, have you had a colonoscopy in the past 5 years?**

□ Yes □ No

**Have you had a Hysterectomy?**

□ Yes □ No

If yes: which hospital and when? _____

For what reason? *(e.g. "fibroids, bleeding, prolapse"):* _____

What type?

- □ Vaginal Hysterectomy
- □ Abdominal Hysterectomy
- □ Laparoscopic or Robotic Hysterectomy

**Have you had your ovaries removed?**

□ Yes □ No

**Have you had previous surgery for urinary incontinence?**

□ Yes □ No

If yes: which hospital and when? _____

What type?

- □ Sling procedure
- □ Burch or MMK
- □ Needle Suspension
- □ Urethral Injection

**Have you had any previous surgery for pelvic relaxation / prolapse?**

- □ Yes □ No
- □ If yes: which hospital and when?

  _____
- □ What type?
- □ Vaginal incision
- □ Abdominal incision
- □ Laparoscopic or robotic

**List any other operations, and the year performed:**

_____
_____
_____

## MEDICATIONS

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

_____
_____
_____
_____
_____

## ALLERGIES

Do you have any drug allergies? Y N

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

_____

## FAMILY & SOCIAL HISTORY

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

Heart Disease _____
Stroke _____
Ovarian Cancer: _____
Breast Cancer _____
Other Cancer (please list type) _____
Kidney Disease _____
Blood / Clotting Disorder _____
Other Family Diseases: _____

Do you smoke:

- □ No
- □ Yes

## GENERAL REVIEW OF SYMPTOMS

Please check if you've recently had any of the following:

- □ Fever or chills
- □ Rashes
- □ Headache
- □ Blurred vision
- □ Chest pain
- □ Shortness of breath
- □ Heartburn
- □ Blood in Stool
- □ Muscle aches/pain
- □ Easy bruising/bleeding
- □ Dizziness
- □ Anxiety

# 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 bulge 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 | | | | |

## OAB-Q Questionnaire

This questionnaire will review how much you have been bothered by selected bladder symptoms. Please place a check mark or X in the box that best describes the extent to which you were bothered by each sympton during the past 4 weeks. There are no right or wrong answers. Please be sure to answer every question.

| **During the past 4 weeks, how bothered where you by……** | **Not at all** | **A little bit** | **Some-what** | **Quite a bit** | **A very great deal** |
|---|---|---|---|---|---|
| 1. An uncomfortable urge to urinate? | | | | | |
| 2. A sudden urge to urinate with little or no warning? | | | | | |
| 3. Accidental loss of small amounts of urine? | | | | | |
| 4. Nighttime urination? | | | | | |
| 5. Waking up at night because you had to urinate? | | | | | |
| 6. Urine loss associated with a strong desire to urinate? | | | | | |

# Sexual Function Questionnaire (PISQ-12)

The next set of items covers material that is sensitive and personal. Specifically, these questions ask about matters related to your sexual activity in the past month. We realize that for some women, sexual activity is an important part of their lives; but for others it is not. To help us understand how your bladder and pelvic problems might affect your sexual activity, we would like you to answer the following questions from your own personal viewpoint.

While we hope you are willing to answer all of these confidential questions, if there are any questions you would prefer not to answer, you are free to skip them. Please select the most appropriate response to each question. Remember these questions are only relevant to sexual activity in the <u>past month</u>.

**In the past month, have you engaged in sexual activities with a partner?**

☐ **Yes → complete only <u>Section A</u> below**
☐ **No → complete only <u>Section B</u> below**

**<u>SECTION A:</u> If you <u>have</u> engaged in sexual activity with a partner in the last month**

| | |
|---|---|
| Q1. *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.*<br>1.___Never<br>2.___Seldom<br>3.___Sometimes<br>4.___Usually<br>5.___Always | Q2. *Do you climax (have an orgasm) when having <u>sexual intercourse</u> with your partner?*<br>1.___Never<br>2.___Seldom<br>3.___Sometimes<br>4.___Usually<br>5.___Always |
| Q3. Do you feel sexually excited (turned on) when having sexual activity with your partners?<br>1.___Never<br>2.___Seldom<br>3.___Sometimes<br>4.___Usually<br>5.___Always | Q4. On a 5-point scale where "1" indicates very satisfied and "5" indicates not at all satisfied, how satisfied are you with the variety of sexual activities in your current sex life?<br>1.____Very Satisfied<br>2.____Satisfied<br>3.____Neurtal<br>4.____Less Satisfied<br>5.____Not at all Satisfied |
| Q5. *Do you feel pain during sexual intercourse?*<br>1.___Never<br>2.___Seldom<br>3.___Sometimes<br>4.___Usually<br>5.___Always | Q6. Are you incontinent of urine (leak urine) with sexual activity?<br>1.___Never<br>2.___Seldom<br>3.___Sometimes<br>4.___Usually<br>5.___Always |

| | |
|---|---|
| Q7. *Does fear of incontinence (either stool or urine) restrict your sexual activity?*<br>1.___Never<br>2.___Seldom<br>3.___Sometimes<br>4.___Usually<br>5.___Always | Q8. Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum or vagina?)<br>1.___Never<br>2.___Seldom<br>3.___Sometimes<br>4.___Usually<br>5.___Always |
| Q9. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame, or guilt?<br>1.___Never<br>2.___Seldom<br>3.___Sometimes<br>4.___Usually<br>5.___Always | Q10. Does your partner have a problem with <u>erections</u> that affects your sexual activity?<br>1.___Never<br>2.___Seldom<br>3.___Sometimes<br>4.___Usually<br>5.___Always<br>6.___Not Applicable |
| Q11. Does your partner have a problem with <u>premature ejaculation</u> that affects your sexual activity?<br>1.___Never<br>2.___Seldom<br>3.___Sometimes<br>4.___Usually<br>5.___Always<br>6.___Not Applicable | Q12. Compared to orgasm you have had in the past, how intense are orgasms you have had in the past month?<br>1.___Much more intense<br>2.___More intense<br>3.___Same intensity<br>4.___Less intense<br>5.___Much less intense |

**<u>SECTION B</u>: If you <u>have</u> <u>not</u> had sexual activity with a partner in the last month**

| | |
|---|---|
| Q1. *Do you have a partner at this time?*<br>1.___Yes<br>2.___No | Q2. 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.<br>1.___Never<br>2.___Seldom<br>3.___Sometimes<br>4.___Usually<br>5.___Always |
| Q3. On a 5-point scale where "1" indicates very satisfied and "5" indicates not at all satisfied, how satisfied are you with the variety of sexual activities in your current sex life?<br>1.____Very Satisfied<br>2.____Satisfied<br>3.____Neurtal<br>4.____Less Satisfied<br>5.____Not at all Satisfied | Q4. Does fear of pain during sexual intercourse restrict your activity?<br>1.___Never<br>2.___Seldom<br>3.___Sometimes<br>4.___Usually<br>5.___Always |

| | |
|---|---|
| Q5. Does fear of incontinence (either stool or urine) during Sexual intercourse restrict your sexual activity?<br>1.___Never<br>2.___Seldom<br>3.___Sometimes<br>4.___Usually<br>5.___Always | Q6. Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum or vagina)?<br>1.___Never<br>2.___Seldom<br>3.___Sometimes<br>4.___Usually<br>5.___Always |

## Information for Medicare Recipients about Your Bill for Today's Visit

**As a Medicare beneficiary, you may be receiving two bills for today's visit that together represent the total cost of the visit.** This is because Medicare has designated NorthShore Medical Group practices as "Provider-Based" sites of care. This designation recognizes that our practices operate as extensions of our hospitals, meeting rigorous standards for quality care, infection control, patient confidentiality and more, while submitting to periodic, unannounced inspections by state and federal authorities.

While Provider-Based designation is not typical or required of physician practices, we believe this status bears testament to our overriding commitment to superior care and continuous quality improvement.

**Medicare requires that Provider-Based sites bill patients separately for the professional services provided by physicians (Professional fees), and for the expenses associated with providing the care (Facility/Technical fees), such as office space, nursing, and supplies.**

*Here are a few important things for you to know about these bills:*

- The sum of the two bills you may receive reflects the same total charge that is billed to non-Medicare patients.
- One bill will be from the physician for today's visit and will note the charges for his/her professional services.
- A second bill will be from the NorthShore Hospital Billing Service and will note the facility/technical charges for use of the physician office space, medical supplies, and nursing staff. The bill comes from the NorthShore Hospitals because our offices are designated by Medicare as extensions of our hospitals.
- Both bills may be subject to Medicare's deductible and coinsurance. This means that you may be responsible for coinsurance on both bills. The coinsurance amounts are determined by Medicare and are based on the services performed.
- Typical coinsurance amounts for the most common services provided in our office are listed on the following page:

| Service | Hospital Co-Insurance | Professional Co-Insurance | Total Co-Insurance |
|---|---|---|---|
| Office visit or consultation | $10.00 - $18.00 | $5.00 - $30.00 | $15.00 - $48.00 |
| Nurse visit | $10.00 - $18.00 | $0.00 | $10.00 - $18.00 |
| EKG | $5.00 | $1.00 - $6.00 | $6.00 - $11.00 |
| Flu shot | $0.00 | $0.00 | $0.00 |
| Welcome to Medicare Physical | $15.00 - $20.00 | $15.00 - $20.00 | $30.00 - $40.00 |
| Urinary system tests | $15.00 - $340.00 | $15.00 - $80.00 | $30.00 - $420.00 |
| Nerve conduction tests | $5.00 - $15.00 | $10.00 - $20.00 | $15.00 - $35.00 |

- **Please note that the above ranges are only estimates.** Your total responsibility will depend on the actual services received.

- Supplemental insurance benefits you may have may provide additional coverage. Contact your supplemental insurance company if you have questions.

Please refer to the phone numbers listed on your bills for assistance with any additional questions you may have about charges for your care. Should you have questions that Medicare could answer, please contact your Medicare Representative at 800-633-4227.