SOUTH COAST UROGYNECOLOGY WELCOMES YOU

… and thanks you for selecting us for your healthcare needs. We are dedicated to providing you with the best personalized healthcare and solutions. To help us do this, please fill out this form completely in ink. If you have any questions or need help, please ask us. We will be happy to help you. Complete this form prior to your visit if possible.

PERSONAL INFORMATION

Today's date_____ Social Security_____ Birthday_____
Name_____
Address_____
City/State/Zip_____
Age_____ ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Employer_____
Referred By_____ Primary Physician_____
Primary Physician Address_____
Primary Physician Phone #_____ Fax #_____

TELEPHONE INFORMATION

Home Phone_____ Work Phone_____ Ext_____
E-Mail_____ Cell Phone_____
(We prefer and encourage e-mail communication for speed and efficiency)
When is it the best time to reach you? ☐Mon ☐Tue ☐Wed ☐Thu ☐Fri
Where do you prefer to receive calls? ☐Home ☐Work ☐Cell Phone
Emergency Contact _____ Relationship _____
Home Phone _____ Work Phone _____ Cell Phone _____

RESPONSIBLE PARTY

Who is responsible for this account?
Name _____ Relationship to Patient _____
Address (if different from patients) _____
City/State/Zip_____
Social Security # _____ Drivers License # _____ Birthdate _____
Employer _____ Occupation _____
Home Phone _____ Work Phone _____ Cell Phone _____

INSURANCE INFORMATION

Primary Insurance		Secondary Insurance	
Name of Insurance	_____	Name of Insurance	_____
Subscriber #	_____	Subscriber #	_____
Group #	_____	Group #	_____
Name of Insured	_____	Name of Insured	_____
Relationship to patient	_____	Relationship to patient	_____
Insured's Birthdate	_____	Insured's Birthdate	_____
Soc Sec. #	_____	Soc Sec. #	_____

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT

PLEASE READ AND SIGN THE FOLLOWING:
I hereby assign all medical/surgical benefits to **South Coast Urogynecology, Inc./Dr. Red Alinsod** and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of information necessary to secure the payment of benefits. I further agree that a photocopy of the agreement shall be as valid as the original.

SIGN HERE_____Date _____Time _____

SOUTH COAST
UROGYNECOLOGY

HIPAA Notice of Privacy Practice

How We Collect Information About You: South Coast Urogynecology and its employees and collect data through the following but not limited to the submission of the Health and Physical (H&P) registration forms, letters, phone calls, emails, and office notes either required by law, or necessary to process requests for medical care through our organization.

What We Do Not Do With Your Information: Information about your financial status and medical conditions and care that you provide to us in writing, by phone, via email (including information left on voice mails), contained in or attached to your medical chart, or directly or indirectly given to us, is held in the strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about patients or clients who receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient or client.

How We Do Use Your Information: Information is only used as is reasonably necessary to provide you with health care services which may require communication between South Coast Urogynecology providers, medical produce or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance.

If you apply or attempt to apply to receive assistance through us and provide information with the intent of purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect: We do not use cookies on our website to collect data from our site visitors. We do not collect information about site visitors except for a hit counter that simply records the number of visitors and no other data.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of South Coast Urogynecology. We reserve the right to use non-identifying information about our patients or clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

Authorization to leave messages

I give my permission for the staff of South Coast Urogynecology to give or leave messages or information regarding medication, surgery, lab results, appointments and healthcare by the following checked options.

☐ My home telephone answering machine _____

☐ My email address _____

☐ My cell phone voice message _____

☐ With a family member (name & contact#) _____

Signature of patient or responsible party _____

Print Name _____Date _____Time _____

SOUTH COAST
UROGYNECOLOGY

PAYMENT POLICY

Thank you for choosing us as your specialist. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in some insurance plans, including Medicare. If you are not insured, or not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your **coverage.**
2. **Credit Card.** You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you. This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. This will lower our billing costs. The combination will benefit everybody in helping to keep the cost of health care down. This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. We will charge you only the portion of the insurer-determined payment not paid by the insurer. We will not do "balance billing", which is asking you to pay the difference between our normal fee and the insurer's normal payment. We will accept your insurer's allowable billing amount. This policy may not apply if you are a cash-paying patient.
3. **Co-payments and deductibles.** All co-payments must be paid before or at the time of service. All deductibles must be paid when the amount is known. The arrangement is part of your contract with your insurance company. This fee is your responsibility. We cannot guarantee the deductible amount since it varies among patients and their plans and what services have been accessed in the recent past. It is best to call your insurance company.
4. **Non-covered services.** Please be aware that some and perhaps all of the services you receive may be non-covered, considered investigational by some health plans, or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
5. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
6. **Claim submission.** As a courtesy to you, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. It is your responsibility to ask your plan what is covered and what is not covered.
7. **Coverage.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
8. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail, that you have 30 days to find alternative medical care. During the 30 day period, our physician will only be able to treat you on an emergency basis.
9. **Missed appointments.** We may charge a $25 fee for missed appointments not canceled within 24 hrs. These charges will be your responsibility.
10. **Bounced checks.** Please be advised there is a $25 fee for any bounced or returned checks.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the Payment Policy and agree to abide by its guidelines.

Signature of patient or responsible party _____

Print Name _____Date _____Time _____

SOUTH COAST
UROGYNECOLOGY

PAYMENT POLICY FOR AESTHETIC SURGERY

Dr. Alinsod is the leading surgeon in his field of expertise and takes great pride providing quality and confidential care. Patients are exceptionally valued and provided extensive consultation time with both Dr. Alinsod and our patient liaison, enabling all questions and concerns to be addressed well in advance of scheduled surgery.

As you can imagine, surgical slots are at a premium. A great deal of thought has been given for evaluation, preparation, surgery time, and staffing needed for each procedure. In consideration for Dr. Alinsod's time, staff members, and fellow clients, we have an unwavering financial policy.

A 50% deposit is required at the time of scheduling surgery. This allows us to block the time needed for your surgery. The remaining balance is due one week prior to surgery. All fees must be received one week prior to surgery. A nonrefundable 50% of the deposit will be retained for a cancelled surgery that is not reschedule with Dr. Alinsod.

We accept cash, all major credit cards, and cashiers checks. A 5% discount will be given for cash payments. Personal checks are not accepted. We provide several financing options and would be happy to discuss those with you.

Please note, additional surgical procedures cannot be added on the day of surgery unless payment in full has been received.

I have read and understand the Payment Policy for Aesthetic Surgery and agree to abide by its guidelines.

Signature of patient or responsible party _____

Print Name _____Date _____Time _____

SOUTH COAST UROGYNECOLOGY
THE WOMEN'S CENTER
Alinsod Institute for Aesthetic Vaginal Surgery

INITIAL HISTORY AND PHYSICAL **Date:_____**

Appropriate sections to be completed by patient

Patient Name_____ **Medical Record #_____**
Age_____ Date of Birth _____
Pregnancies_____ Births____(Vaginal ____Cesarean____) **Miscarriages____ Abortions____**
Address: _____
_____
_____
Phone (Home) _____ **Allergies**: ☐None
Phone (Work) _____ ☐Yes_____
Phone (Cell) _____ _____
Phone (Fax) _____ _____
Email _____

Referring Physician: _____
Primary Care Physician: _____

How did you hear about us? _____

CHIEF COMPLAINT (Why you want to see the doctor today?)
_____
_____
_____
_____
_____
_____
_____

AVS (Aesthetic/Vaginal Surgery) QUESTIONAIRE

☐ **Skip this section. I have no problems with aesthetics or function of my vaginal area.**

____	I want aesthetic vaginal surgery	____	I have had difficult births
____	My labia are larger than what I want	____	My vagina feels too loose
____	I do not like the way my labia looks	____	I have decreased sensations
____	My labia rub, tug, and pull on my clothing	____	I feel pelvic heaviness
____	I am unable to wear the type of clothing I want	____	I rely on my appearance at work
____	I have had unflattering comments about my genital region	____	Sex is uncomfortable and unpleasant at times

☐	I want Laser Hair or/and Vein reduction	☐	I want Botox
☐	I want Laser/Fotofacial/Fraxel/Skin Tightening	☐	I want Skin Fillers
☐	I want Laser Scar Reduction	☐	I want Scar/Stretch Marks Reduction

Patient Name_____

BLADDER SYMPTOM QUESTIONNAIRE

☐ **Skip this section. I have no bladder/kidney or urinary problems.**

How often do you urinate: during the **day**? _____Times
during the **night**? _____Times

Do you leak urine (incontinence)?	Yes No
Duration of incontinence? _____Months _____ Years	
Is it caused by **coughing, laughing, sneezing, running, sports**, etc.?	Yes No
Is the amount of urine you usually pass :	Large Average Small
Do you have difficulty starting your urinary flow?	Yes No
Do you strain to void your urine?	Yes No
Do you feel that you empty your bladder completely?	Yes No
Do you notice dribbling of urine after voiding?	Yes No
Do you have to assume abnormal positions to urinate?	Yes No
Do you need to wear protective 'pads' for this type of incontinence?	Yes No
Are you bothered by a **strong sense of urgency** to void?	Yes No
Can you overcome the sensation of urgency to void?	Yes No
Do you sometimes not make it to the bathroom in time (urgency?)	Yes No
What activities seem to cause you to loose control of your urine?	
- sight, sound or feel of running water	Yes No
- standing up after being seated or lying down	Yes No
- "key in the door" when you return home	Yes No
Do you lose your urine during intercourse?	Yes No
if yes - with deep penetration	Yes No
- with orgasm?	Yes No
Do you lose urine without any warning (without activity or urgency)	Yes No
When urinating, can you usually stop your stream?	Yes No
Do you ever wet the bed while asleep?	Yes No
Would you describe the amount of urine that you leak as being (you may answer more than one)	
- frequent small volumes……	Yes No
- unconscious/continuous loss (always damp or wet)	Yes No
- infrequent but single large volumes of loss …….	Yes No

Is your urine flow: (circle one) Strong Weak Dribbling Intermittent

How many pads do you usually use per day for protection? (circle) 1, 2, 3, 4, 5, 6, 7, 8, more.

Has urine leakage limited your ability to:	not at all | min | mild | mod | greatly
- do household chores (cooking, house-cleaning, laundry)?	0 1 2 3 4
- recreation such as walking, swimming, or other exercise?	0 1 2 3 4
- participate in activities (church, movies, concerts)?	0 1 2 3 4
- travel more than 30 minutes from home?	0 1 2 3 4
- participate in social activities outside your home?	0 1 2 3 4
- participate in, enjoy, or feel comfortable with sexual activity?	0 1 2 3 4
Do you have reduced self-esteem, depression, frustration, nervousness?	Yes No
Do you have frequent urinary infections?	Yes No
How often have these occurred in recent years? 1, 2, 3, 4 or more per year. (circle choice)	
Do you ever see blood in your urine?	Yes No
Do you have pain during urination?	Yes No
Do you have pain in the lower abdomen?	Yes No
Is the pain related to:	
- your bladder being full?	Yes No
- your menstrual cycle?	Yes No
- intercourse?	Yes No
- bowel movements?	Yes No

Patient Name_____

GYNECOLOGIC QUESTIONNAIRE

Do you have menstrual periods? _____Yes _____No (skip to PAP Questions below)
Date of last menstrual period:_____
If you have periods, are they: **regular / irregular, heavy / moderate / scant / painful**? Circle
If Irregular periods, for how long? _____Months _____Years
If you have painful periods, does the pain occur **before** or **during** or **after** menses? Circle
If painful periods, for how long? _____Months _____Years
If you no longer have menstrual periods:

Hysterectomy:	Yes No
Surgical removal of your ovaries?	Yes No

When was your last PAP smear? _____ Normal / Abnormal. Circle

Have you had treatments for abnormal PAPs?	Yes No
If yes, please explain: _____	
Are you having any abnormal vaginal discharge or discomfort?	Yes No
Do you have a feeling of vaginal fullness or pressure?	Yes No
Can you see or feel a swelling protruding from the vagina?	Yes No
Do you push the protrusion back to have a BM or empty your bladder?	Yes No
Are you sexually active?	Yes No
Are your partner(s): Men_____ Women_____ Both_____	
Do you have any sexuality concerns to discuss with us?	Yes No
If yes, please explain:_____	

Birth Control:

Do you have a need for birth control?	Yes No
Are you or your partner using any birth control now?	Yes No
If yes, what method?_____ ___	
Are you satisfied with this method?	Yes No
Have you ever had a sexually transmitted disease?	Yes No
If yes, please explain:_____	
Do you have recurrent bladder infections?	Yes No
If yes, (1) Please explain: _____	
(2) Have you had kidney infection(s)?	Yes No

Hormone Questionnaire:

Do you take (or have you ever taken hormone replacement?	Yes No
Are you interest in Bio-Identical Hormone Replacement Therapy?	Yes No
Are you experiencing any of the following symptoms?	
Hot flashes	Yes No
Night Sweats	Yes No
Sleep Disturbance	Yes No
Loss of Libido/Sexual Desire	Yes No
Vaginal Dryness	Yes No
Fatigue and tiredness	Yes No
Mood Swings and Irritability	Yes No
Anxiety and Muscle Tension	Yes No
Forgetfulness	Yes No
Hair Loss	Yes No
Skin Disorders	Yes No

Patient Name_____

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS (other current health problems):

☐ **Skip this section. I am completely healthy without any conditions mentioned below.**

Are you physically active? Yes No What type of exercise? _____

Describe_____

Do you now have or have you ever had:

Neurologic (seizures, headaches, weakness, paralysis) problems? Yes No _____

Psychiatric problems? Depression? Mania? Bipolar? Yes No _____

Head/Ear/Eyes/Nose/Throat Problems? Yes No _____

Thyroid problems? Yes No _____

Cardiac (heart) problems? Palpitations? Chest Pain? Irregular Beat? Yes No _____

Lung Problems? Asthma? Short of Breath? Yes No _____

Breast Problem? Mass? Lumpiness? Discharge? Pain? Yes No _____

Gastrointestinal (stomach) problems? Yes No _____

Kidney or bladder disease? Stones? Infections? Yes No _____

Liver problems? Yes No _____

Hematologic (bleeding, anemia) bleeding problems? Yes No _____

Diabetes (insulin dependent/oral medication) Yes No _____

Musculoskeletal (bones, joints, muscles) problems? Yes No _____

Circulation problems (varicose veins, thrombosis)? Yes No _____

Cancer Yes No Type _____

High Blood Pressure Yes No _____

OtherProblems_____

_____

PAST SURGERIES OR HOSPITALIZATIONS

☐**NONE**

Please list with date:

_____

_____

_____

_____

_____

FAMILY HISTORY (check illness which has occurred in any blood relative and write relationship to you):

____ Cancer (type and In whom) _____

____ Bleeding Disorder _____

____ Heart disease _____

____ Diabetes _____

____ Others _____

_____

SOCIAL HISTORY

Marital status: S M W D

Occupation ☐Not Workinig ☐Working: What Occupation?_____

Tobacco use: Yes No Daily amount _____Number of years_____

Alcohol use: Yes No Daily amount _____

Drug use Yes No Daily amount _____Which Drugs? _____

Caffeine Use: Yes No Daily amount _____

Abuse Yes No Describe_____

Other: _____

_____

Patient Name_____

MEDICATION HISTORY
☐NONE

- Please list all current medications, including vitamins, herbal medications and mineral products and pertinent information requested, to the best of your knowledge.
- This list will assist Dr. Alinsod, nurses and/or hospital staff (if required in the case of surgery) in preventing ALLERGIC REACTIONS and DRUG INTERACTIONS.
- This list MUST be updated with every visit.

MEDICATION / VITAMIN HERBAL MEDICATION/ MINERAL PRODUCTS: *(Name)*	**Prescription**	**OTC**	**DOSAGE** *(g, mg, mcg, u)*	**ROUTE** *(by mouth, injection, application, etc…)*	**HOW OFTEN?** *(1 or 2x a day, before bed)*	**REASON:** *Why are you taking this medication?*

ALLERGIES:
☐**NONE**: No known allergies (**NKA**)
☐LIST ALLERGIES AND TYPE OF REACTION BELOW
_____
_____
_____

REVIEW OF SYSTEMS:

LAST MAMMOGRAM_____ LAST LIPID PANEL_____
LAST COLONOSCOPY_____ LAST FASTING SUGAR_____
LAST BONE SCAN_____

PUF QUESTIONAIRE SCORE_____Date_____

(Skip pages 6-9. These are to be completed by the doctor or nurse)

Patient Name_____

EXAMINATION: Date of Exam_____

Constitutional: Ht_____ Wt_____
Temp_____ BP _____ Pulse _____ Respiration _____

	Normal	**Abnormal**		
Appearance:	[ ]	[ ]	_____	
HEENT:	[ ]	[ ]	____No thyromegaly ____Throat clear	
Heart:	[ ]	[ ]	____No murmurs ____No heaves ____No gallops ____No irregularities	____Murmur ____Irregular Rhythm
Lungs:	[ ]	[ ]	____Clear ____No Rales ____No Wheeze	____Congested Sounding ____Rales ____Wheeze
Breast/Chest:	[ ]	[ ]	____No Mass ____No Discharge ____Lymp Node Survey Normal	____Fibrocystic Changes ____Abnormal Discharge ____Abnormal Nodes
Abdomen:	[ ]	[ ]	____Soft ____No Masses ____Non-Tender ____Bowel Sounds Normal	____Scars ____Mass Palpated ____Tender
Extremities:	[ ]	[ ]	____No Cyanosis ____No Clubbing ____No Edema ____No Malformations	

Skin Lesions ☐None _____
Lymph Nodes ☐Normal _____
Hernias ☐None _____

Other
_____
_____
_____
_____
_____

Drawing:

Patient Name_____

UROGYNECOLOGIC EXAM: **DATE of EXAM**:_____

Introitus:		Normal	Virginal	Stenotic	Parous
Estrogenization		Normal	Atrophic		
Neurologic:	Clitoral Reflex:	Normal	Decreased	Absent	
	Anal wink:	Normal	Decreased	Absent	
Perineal Body:		Normal	Shortened	Bulging	
Vulvar/Perineal/Vaginal		Normal	Labial Enlargement		Labial Assymetry
Urethra: Appearance		Normal	_____		
Urethral Hypermobility:		None	0, +, ++, +++		

Stress Test:	Upright	Negative	Positive	
	Standing	Negative	Positive	
Empty Bladder Stress Test		Negative	Positive	
Urethral Hypermobility		Negative	Positive	
Q-Tip Test:		Negative	Positive_____	Degrees
Spontaneous Cough Strain Volume:		+, ++, +++		

BLADDER SCAN: _____

Vagina Pelvic Floor Musculature: Tone: Good Fair Poor
Cystocele: (lateral / central / combined defect) Stage 0, 1, 2, 3, 4
Rectocele: (distal / proximal) Stage 0, 1, 2, 3, 4
Enterocele: Stage 0, 1, 2, 3, 4
Vaginal cuff prolapse Stage 0, 1, 2, 3, 4
Vaginal Length: ____normal ____shortened ____deep
Vaginal Lesions:_____
Tenderness: (none / cuff / levator / bladder / introital/ uterus)
Uterus Present _____ Absent _____
Size (normal / enlarged / atrophic) _____week size
Prolapse Stage 0, 1, 2, 3, 4
Describe _____
Adnexa Masses: ____None
Right _____
Left _____
Andexal Tenderness ____None
Right _____
Left _____
Rectal Exam: ____Normal
____No Mass ____Mass Palpated
Rectal Tone: ____Normal ____Abnormal
Hemorrhoids: ____None ____External ____Internal

☐Vaginal Laxity_____
☐Enlarged/Loose ____Labia Minora ____Labia Majora
☐Assymetric Labia Minora
☐Excess Clitoral Hood

Pelvic Organ Prolapse Assessment **Drawing**

Patient Name_____

IMPRESSION:
_____Normal & Healthy Annual Examination
_____Requests Contraception
_____Peri-menopause/Menopause ____Requests Hormones
_____SUI (Stress Incontinence)
_____ISD (Instrinsic Sphincter Defficiency)
_____DO (Detrussor Over Activity)
_____OAB Wet Dry
_____Overflow Incontinence
_____Mixed Incontinence
_____Cystocele Grade 0 1 2 3 4
_____Rectocele Grade 0 1 2 3 4
_____Enterocele Grade 0 1 2 3 4
_____Uterine Prolapse Grade 0 1 2 3 4
_____Vaginal Prolapse Grade 0 1 2 3 4
_____Labial Enlargement/Asymmetry
_____Vaginal Laxity
_____IC
_____CPP ☐Endometriosis/Adenomyosis ☐Adhesions ☐Infection
_____AUB ☐Polyps ☐Fibroids
OTHER_____
OTHER_____
OTHER_____
OTHER_____

PLAN & RECOMMENDATIONS:

☐PAP	☐Lipids	☐Hormone Panel	☐CBC	☐UA + C&S
☐Mammo	☐FBS	☐Thyroid Panel	☐Chem Panel	☐Pregnancy Test
☐GC/Chlam	☐DNA	☐Vag Culture	☐Wet Mount	☐Colposcopy
☐Cystoscopy	☐IC Test	☐Bladder Study	☐Hysteroscopy	☐EMBx
☐SLING/CYST	☐ENT REP	☐VAGINOPLASTY	☐HTA	☐HEMORRHOIDECTOMY
☐ANT REP	☐UTER SUSP	☐PERINEOPLASTY	☐EM RESECTION	☐RENESSA
☐POST REP	☐MESH	☐LABIA MAJ PLASTY	☐EM ABLATION	☐LAPAROSCOPY
☐SSLS	☐BIOLOGIC	☐LABIA MIN PLASTY	☐D&C	☐LOA
☐PIVS	☐SITE SPECIF	☐CLIT HOOD REDUC	☐BLAD BOTOX	☐FOL

_____
_____
_____

Other:_____
_____

CONSULTATIONS SCHEDULED:
Pre-Op With_____
Anesthesia_____
Other _____

FOLLOW UP ____**Days** ____**Weeks** ____**Months** ____**Year/s**

SIGNATURE _____

DATE _____

DICTATED _____

REVIEWED _____

NO CHANGES _____

CHANGES _____

DATE _____

SOUTH COAST UROGYNECOLOGY

Patient Name_____Medical Record #_____

PRE-OP NOTE: The surgical case was discussed with the patient at length. The surgery/s is/are:

____Suburethral Sling, Cystoscopy
____Anterior Repair, Paravaginal Repair
____Posterior Compartment Repair
____Enterocele Repair
____Vaginal Vault Suspension
____SSLS
____PIVS
____Uterine Suspension

____TVH, Total Vaginal Hysterectomy
____TAH, Total Abdominal Hysterectomy
____LSH, Laparoscopic Supracervical Hys.
____LH, Laparoscopic Hysterectomy
____LAVH, Laparoscopically Assisted Vaginal Hysterectomy

____Labiaplasty:____Minora ____Majora
____Vaginoplasty
____Perineorrhapy/Perineoplasty
____Laser Resurfacing ____Hair Reduction
____Hymenoplasty
____Clitoral Hood Reduction
____Hemorrhoidectomy

____Laparoscopy
____Lysis of Adhesions
____Fulguration of lesions
____Cystectomy
____LUNA, Laparoscopic Uterine Nerve Ablation
____Ureteral Dissection
____Laparotomy

____Band Release
____Bilateral Salpingo-oophorectomy
____Unilateral Salpingo-oophorectomy
____Ovarian Cystectomy

____Hysteroscopy
____Endometrial Resection
____Endometrial Ablation/HTA
____Polypectomy
____Myomectomy
____Septoplasty
____Dilatation and Curretage
____Cystoscopy with Bladder Botox

_____
_____

Options of surgery were discussed such as expectant management, medical management, no surgery,
_____
_____

Risks of surgery were also discussed such as anesthesia, infection, bruising, bleeding, hemorrhage, transfusion, HIV, Hepatitis, anaphylaxis, aspiration, damage to internal organs such as bowel, bladder, urethra, ureter, major vessels, nerves, et al. Incisional hernias were discussed. The possibility of catheterization may be needed, an indwelling catheter may be used, and the possibility of urinary retention was also discussed and accepted. The possibility that the procedure may fail or a recurrence of symptoms may occur was also discussed at length. She understands further procedures or surgeries may be needed in the future for revision/repair/removal. No guarantees are implied or given to the patient regarding the safety and efficacy of the procedure. She has had a chance to ask all her questions to her satisfaction. The option to decline or delay surgery has been discussed at length. The patient wishes to proceed with surgery.

☐The possibility of infection/rejection/erosion/pain, due to mesh or tissue were discussed, if they are used. The type of implant (if needed) was discussed fully with the patient and she has agreed to its use in repairs. She understands that pain/dyspareunia may occur with and without the use of mesh or tissue.
_____
_____

PATIENT SIGNATURE _____

PHYSICIAN SIGNATURE _____

DATE _____

REVIEWED _____

NO CHANGES _____

CHANGES _____

DATE _____

QUALITY OF LIFE & SYMPTOMS DISTRESS INVENTORY

NAME_____DATE_____

Please answer each question by checking the best response
Between 0 (not at all) and 3 (greatly).
Incontinence impact questionnaire

Has urinary leakage and/or prolapsed affected your:	0= not at all	1= slightly	2= moderately	3= greatly	
1. Ability to do household chores (cooking, housecleaning, laundry)?					PA
2. Physical recreation such as walking, swimming, or other exercise?					PA
3. Entertainment activities (movies, concerts, etc.)?					T
4. Ability to travel by car or bus more than 30 minutes from home?					T
5. Participation in social activities outside your home?					SR
6. Emotional health (nervousness, depression, etc.)?					EH
7. Feeling frustrated?					EH

Urogenital distress inventory

Do you experience, and, if so, how much are you bothered by:	0= not at all	1= slightly	2= moderately	3= greatly	
1. Frequent urination?					I
2. Urine leakage related to the feeling of urgency?					I
3. Urine leakage related to physical activity, coughing, or sneezing?					S
4. Small amounts of urine leakage (drops)?					S
5. Difficulty emptying your bladder?					OD
6. Pain or discomfort in the lower abdominal or genital area?					OD
7. A feeling of bulging or protrusion in the vaginal area?					OD
8. Bulging or protrusion you can see in the vaginal area?					OD

PA=physical activity; T=travel; SR=social/relationships; EH=emotional health;
OD=obstructive/discomfort symptoms; I=irritative symptoms; s=stress symptoms

Patient Name_____

INTAKE & VOIDING DIARY

This chart is a record of your fluid intake, voiding and urine leakage.
Choose 4 days (entire 24 hours) to complete this record – they DO NOT have to be in a row.
Pick days in which will be convenient for you to measure EVERY void.
Please bring this diary to your next visit.

INSTRUCTIONS:
1. Begin recording upon rising in the morning-continue for a full 24 hours.
2. Record separate times for voids, leaks and fluid intake.
3. Measure voids in "cc's" using the hat.
4. Measure fluid intake in ounces.
5. When recording a leak – please indicate the volume ("1,2, or 3"), your activity during the leak, and if you had an urge ("yes" or "no")

Example of entries

DATE:

TIME	**Amount voided** (in ccs)	**LEAK Volume** 1=drops/damp 2=wet-soaked 3=bladder emptied	**Activity during leak**	**Was there an urge?**	**Fluid intake** (Amount in ounces/type)
7:00a	*250cc*	*2*	*Running*	*Yes*	
7:30a					*8 oz./Herbal tea*

Patient Name_____

The Pelvic Pain and Urinary/Frequency (PUF) 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+		
2a. How many times do you go to the bathroom at night?	0	1	2	3	4+		
2b. If you get up at night to go to the bathroom, does it bother you?	Never	Midly	Moderate	Severe			
3. Are you currently sexually active? Yes_____ No _____							
4a. If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occassionally	Usually	Always			
4b. If you have pain, does it make you avoid sexual intercourse?	Never	Occassionally	Usually	Always			
5. Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes, or scrotum)?	Never	Occassionall	Usually	Always			
6. Do you have urgency after going to the bathroom?	Never	Occassionally	Usually	Always			
7a. If you have pain, is it usually…		Mild	Moderate	Severe			
7b. Does your pain bother you?	Never	Occassionally	Usually	Always			
8a. If you have urgency, is it usually…		Mild	Moderate	Severe			
8b. Does your pain urgency bother you?	Never	Occassionally	Usually	Always			
					Symptom Score (1, 2a, 4a, 5, 6, 7a, Bal =		
					Bother Score (2b, 4b, 7b, 8b) =		
					Total Score (Symptom Score + Bother Score) =		

Patient Name_____

Family History Questionnaire for Common Hereditary Cancer Syndromes

Please mark below if there is a ***personal or family history*** of any of the following cancers. If yes, then indicate family relationship and ***age at diagnosis*** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	SIBLINGS/ CHILDREN	MOTHER'S SIDE	FATHER'S SIDE
For example: Colorectal cancer		*Brother 36 yrs.*	*Aunt 44 yrs Cousin 58 yrs*	*Grandfather 65 yrs*
BREAST AND OVARIAN CANCER				
Breast cancer				
Ovarian cancer				
Breast cancer in both breasts OR multiple primary breast cancers				
Male breast cancer				
Are you of Ashkenazi Jewish discent?				
COLON AND UTERINE CANCER				
Uterine (endometrial) cancer				
Colorectal cancer				
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer				
10 or more cumulative colon polyps				
MELANOMA				
Melanoma				
Pancreatic cancer				
OTHER CANCER				
_____				