



## Urogynecology & Pelvic Surgery

42 E. Laurel Road \* Suite 1300 \* Stratford, NJ 08084  
Phone: (856) 566-2710 Fax: (856) 566-2755

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Adam S. Holzberg, D.O.

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Welcome to Rowan Medicine Urogynecology & Pelvic Surgery. We are pleased that you have been referred to our office for your Urogynecology needs. Your scheduled appointment with **Dr. Holzberg** is on \_\_\_\_\_ at \_\_\_\_\_ am/pm. Please arrive 15-20 minutes prior to your scheduled appointment unless you have been told otherwise. We often have additional paperwork for you to fill out in order to meet your healthcare needs.

### Before your first visit, Please:

- Complete the enclosed questionnaires, and bring them to your first visit.
- Arrive 15 minutes PRIOR to your appointment to complete additional paperwork.

### Also keep in mind:

- **Come to your first visit with a partially full bladder:** Let the receptionist know if you are uncomfortable on arrival.
- **Initial Examination:** A pelvic examination is usually performed during 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 call (856) 566-2710 as soon as possible.
- **Late Arrival:** In the event you may be late, please call (856) 566-2710 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 Rowan Medicine. If your insurer requires co-payment, you will be required to pay this at the time of service. For billing or insurance questions, please contact the billing office: (856) 770-5738
- **Insurance/Referral:** Please bring your insurance card, and if necessary please contact your primary care physician's office for your insurance referral or you may be responsible for payment in full. Referrals should be made out to Rowan Medicine / Urogynecology and Pelvic Surgery
- **Consultation Request:** Please bring a request from your referring doctor for a consultation as well as a diagnosis of why you are being referred. This can be faxed directly to our office or brought in with you on the day of your appointment. This is not an insurance referral. It is required by our office for billing purposes if you were asked to see us by another practitioner.
- **Records:** Any records that pertain to your condition and you think might be helpful should be brought in at the time of your appointment. This could include labs, tests, other doctor visits as well as reports from previous surgery.
- **RowanMedicine Patient Portal:** Accessible by this link [sompatients@rowan.edu](mailto:sompatients@rowan.edu) offers patients personalized and secure on-line access to portions of their medical records. It enables you to securely use the Internet to help manage and receive information about your health. With the patient portal, you can use the Internet to: request medical appointments, view your health summary electronic health record, view test results, request prescription renewals, access trusted health information resources, and communicate electronically and securely with your medical care team.
- **We welcome your feedback:** If you have any suggestions on how we might improve our practice and/or better serve you, don't hesitate to contact us.



## Urogynecology & Pelvic Surgery

# Driving Directions

### FROM THE NORTH:

- Take the New Jersey Turnpike to Exit 4 to Route 73 North to Route 295 South.
- Follow Route 295 South to Exit 29. Turn left onto access road to Route 30.
- At light turn left onto Route 30 East (White Horse Pike).
- Follow directions from Route 30 below.

### FROM THE SOUTH:

- Follow Route 295 North to Exit 29A to Route 30.
- Follow directions from Route 30 below.

### FROM ROUTE 30:

- Follow Route 30 East (and the blue hospital signs) for 3.3 miles to the traffic light at Laurel Road.
- Turn right onto Laurel Road. Take first left into the School of Osteopathic Medicine Complex and continue straight into Lot A for patient/visitor parking.

# Public Transportation

NJISA is also accessible through regional rail. The [\*\*PATCO Speedline\*\*](#) and the [\*\*Atlantic City Rail Line\*\*](#) serve the Stratford Campus through the Lindenwold Station. The station is approximately a half mile, less than a 10-minute walk, from our campus.



## Urogynecology & Pelvic Surgery

### About Our Center

**Adam S. Holzberg, D.O.** - Dr. Holzberg is currently the Professor and Chair of the Department of Obstetrics & Gynecology at Rowan University School of Osteopathic Medicine. Prior to this, Dr. Holzberg served as the Division Head of Female Pelvic Medicine & Reconstructive Surgery (Urogynecology) at Cooper University Hospital for over 10 years. He completed his B.A. at Rutgers University and attended medical school at the New York College of Osteopathic Medicine of the New York Institute of Technology. He completed both his residency in Ob/Gyn and fellowship in Female Pelvic Medicine and Reconstructive Surgery (Urogynecology) at Cooper University Hospital and is double boarded in both fields. Dr. Holzberg has published several scientific articles and has lectured both nationally and internationally in the field of Urogynecology.

Dr. Holzberg serves as the Secretary to the Board and a founding board member of International Health Care Volunteers, a charitable organization concerned with women's health care worldwide. He has practiced in southern New Jersey for over 20 years and has surgical privileges at Jefferson Health-New Jersey, Virtua Health System, Cooper University Health Care and Inspira Health.

**Our Medical Students, Residents and Fellows:** We are home to a highly regarded medical school, Rowan University School of Osteopathic Medicine. There will be times when Dr. Holzberg has medical students, residents and/or fellows in the office with him. These students and physicians in training can be an integral part of your care as they assist your physician. They at times will see you along with your physician at your initial visit, and also during testing, follow-up and postoperative care. If at any time you choose not to desire them to partake in your care, please just let us know.

## Urogynecology & Pelvic Surgery

### What is a Urogynecologist?

A Urogynecologist is an Obstetrician/Gynecologist who has specialized in the care of women with Pelvic Floor Dysfunction. The Pelvic Floor is the muscles, ligaments, connective tissue, and nerves that help support and control the rectum, uterus, vagina, and bladder. The pelvic floor can be damaged by childbirth, repeated heavy lifting, chronic disease or surgery.

Some problems due to Pelvic Floor Dysfunction and their symptoms are:

1. **Incontinence:** Loss of bladder or bowel control, leakage of urine or feces.
2. **Prolapse:** Descent of pelvic organs; a bulge and/or pressure; 'dropped uterus, bladder, vagina or rectum.'
3. **Emptying Disorders:** difficulty urinating or moving bowels.
4. **Pelvic (or Bladder) Pain:** Discomfort, burning or other uncomfortable pelvic symptoms, including bladder or urethral pain.
5. **Overactive Bladder:** Frequent need to void, bladder pressure, urgency, urgency incontinence or difficulty holding back a full bladder.

### What Kind of Training Does a Urogynecologist Have?

Urogynecologists have completed medical school and a four-year residency in Obstetrics and Gynecology. These doctors become specialists with additional training and experience in the evaluation and treatment of conditions that affect the female pelvic organs, and the muscles and connective tissue that support the organs. The additional training focuses on the surgical and non-surgical treatment of non-cancerous gynecologic problems.

### When Should I See a Urogynecologist?

Although your primary care physician or Ob/Gyn may have knowledge about these problems, a Urogynecologist can offer additional expertise. You should see (or be referred to) a Urogynecologist when you have problems of prolapse, and/or troublesome incontinence or when your primary doctor recommends consultation. Other problems for which you or your doctor might think about consulting a Urogynecologist include: problems with emptying the bladder or rectum, pelvic pain, and the need for special expertise in vaginal surgery.

### What Treatment Options are Available from a Urogynecologist?

A Urogynecologist can recommend a variety of therapies to cure or relieve symptoms of prolapse, urinary or fecal incontinence, or other pelvic floor dysfunction symptoms. He or she may advise conservative (non-surgical) or surgical therapy depending on your wishes, the severity of your condition and your general health. Conservative options include medications, pelvic exercises, behavioral and/or dietary modifications and vaginal devices (also called *pessaries*). Biofeedback and Electric Stimulation are two newer treatment modalities that your Urogynecologist may recommend. Safe and effective surgical procedures are also utilized by the Urogynecologist to treat incontinence and prolapse. He or she will discuss all of the options that are available to treat your specific problem(s) before you are asked to make a treatment decision.



# Urogynecology & Pelvic Surgery

## INITIAL VISIT QUESTIONNAIRE

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### Your referring Physician:

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_

### Your Primary Physician:

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_

### Your Gynecologist:

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_

## ALLERGIES

Do you have any drug allergies?     YES                       NO

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

Drugs	Reactions

## MEDICATIONS



**Urogynecology & Pelvic Surgery**

**LIST ALL MEDICATIONS INCLUDING OVER THE COUNTER VITAMINS AND HERBALS**

START	MEDICATION	DOSAGE	FREQUENCY	STOP



# Urogynecology & Pelvic Surgery

## Obstetric & Gynecologic History

### Gynecologic History

Menopausal Symptoms:  yrs.  
Age of menopause  yrs.

### Menstrual History

Age at Menarche (*first period*)  yrs.

Last menstrual period:

Previous menstrual period:

Average cycle length:  days

Average length of menses:

Amount of flow:  Light  Moderate  Heavy

Regular menstrual cycles:  Yes  No

### Associated symptoms:

- Cramping
- Sweating
- Headache
- Swelling
- Diarrhea

- None
- Hot flushes
- Sweats
- Anxiety
- Depression
- Vaginal dryness
- Mood swings
- Dyspareunia
- Urinary urgency
- Insomnia
- Libido changes

### Pregnancy History

Number of pregnancies \_\_\_\_\_ C/S \_\_\_\_\_ Vaginal \_\_\_\_\_

Number of term deliveries \_\_\_\_\_

Number of pre-term deliveries \_\_\_\_\_

Number of miscarriages \_\_\_\_\_

Number of abortions \_\_\_\_\_

## Urognecology & Pelvic Surgery

### Past Medical History

<input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Abnormal Uterine Bleeding <input type="checkbox"/> Anal Incontinence <input type="checkbox"/> Anxiety <input type="checkbox"/> Asthma <input type="checkbox"/> Back Injury <input type="checkbox"/> Bladder Infection <input type="checkbox"/> Bladder Stones <input type="checkbox"/> Breast Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Cervical Cancer <input type="checkbox"/> Chronic Constipation <input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Colon Cancer <input type="checkbox"/> C.O.P.D. <input type="checkbox"/> C.R.F. <input type="checkbox"/> C V A / Stroke <input type="checkbox"/> Depression <input type="checkbox"/> D V T <input type="checkbox"/> Diabetes-Type 1 <input type="checkbox"/> Diabetes-Type2 <input type="checkbox"/> Emphysema <input type="checkbox"/> Endometriosis <input type="checkbox"/> Fibroids <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Glaucoma <input type="checkbox"/> GYN Surgery	<input type="checkbox"/> Herniated Disc <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Hypertension <input type="checkbox"/> Inflammatory Bowel Disease <input type="checkbox"/> Interstitial Cystitis <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Kidney Cancer/Renal Cell Carcinoma <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stone <input type="checkbox"/> Liver disease <input type="checkbox"/> Lower Back Pain <input type="checkbox"/> Menopause <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Neurological Disorder	<input type="checkbox"/> Ovarian Cancer <input type="checkbox"/> Ovarian Cyst <input type="checkbox"/> Painful Periods <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Pelvic Pain <input type="checkbox"/> Post-Menopausal Bleeding <input type="checkbox"/> Prolapse <input type="checkbox"/> Sciatica <input type="checkbox"/> Spinal Stenosis <input type="checkbox"/> STD/PID <input type="checkbox"/> Urinary Incontinence (Leaking) <input type="checkbox"/> U T I-Recurrent <input type="checkbox"/> Uterine Cancer <input type="checkbox"/> Vulvar Cancer
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Other \_\_\_\_\_

### Past Surgical History

<input type="checkbox"/> Unremarkable <input type="checkbox"/> Abd Surg-type <input type="checkbox"/> Angioplasty <input type="checkbox"/> Appendectomy <input type="checkbox"/> Breast Biopsy <input type="checkbox"/> Breast Surgery <input type="checkbox"/> Bronchoscopy <input type="checkbox"/> CABG <input type="checkbox"/> Cardiac Surgery <input type="checkbox"/> Carpal Tunnel <input type="checkbox"/> Cesarean Section	<input type="checkbox"/> Cholecystectomy <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Colon Resection <input type="checkbox"/> Cone Biopsy <input type="checkbox"/> Cystoscopy BOD <input type="checkbox"/> Cystoscopy BOD w/biopsy <input type="checkbox"/> Gastric Bypass <input type="checkbox"/> Hernia Repair <input type="checkbox"/> Laparoscopic Robotic/ Hysterectomy <input type="checkbox"/> Lumpectomy <input type="checkbox"/> Mastectomy	<input type="checkbox"/> Oophorectomy <input type="checkbox"/> Ovarian Cyst Removal <input type="checkbox"/> POP Surgery <input type="checkbox"/> Rectal Surgery <input type="checkbox"/> SAB D&E ( <i>Miscarriage</i> ) <input type="checkbox"/> TAB D&E ( <i>Abortion</i> ) <input type="checkbox"/> TAH w/BSO ( <i>Abdominal hysterectomy with Ovaries</i> ) <input type="checkbox"/> TAH ( <i>Abdominal hysterectomy</i> ) <input type="checkbox"/> Thyroidectomy <input type="checkbox"/> U.P.P.P <input type="checkbox"/> Urinary Incontinence Surgery <input type="checkbox"/> Vaginal Hysterectomy	<input type="checkbox"/> Anesthesia Problem-No <input type="checkbox"/> Anesthesia Problem-Yes <input type="checkbox"/> Surgical Complications-No <input type="checkbox"/> Surgical Complications-Yes <input type="checkbox"/> Post-Op delinim
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Other \_\_\_\_\_





## Urogynecology & Pelvic Surgery

### Family History

#### Family History

FH Unknown       No Known Family History       No Known Relative

- |   |   |
|---|---|
| <input type="checkbox"/> FH Breast Cancer/Relative _____        | <input type="checkbox"/> FH Multiple Sclerosis/Relative _____     |
| <input type="checkbox"/> FH Colon Cancer/Relative _____         | <input type="checkbox"/> FH Cervical Cancer/Relative _____        |
| <input type="checkbox"/> FH Diabetes/Relative _____             | <input type="checkbox"/> FH Headaches/Relative _____              |
| <input type="checkbox"/> FH Heart Disease/Relative _____        | <input type="checkbox"/> FH Lung Cancer/Relative _____            |
| <input type="checkbox"/> FH Hypertension/Relative _____         | <input type="checkbox"/> FH Melanoma/Relative _____               |
| <input type="checkbox"/> FH High Cholesterol/Relative _____     | <input type="checkbox"/> FH Ovarian Cancer/Relative _____         |
| <input type="checkbox"/> FH Kidney Renal Disease/Relative _____ | <input type="checkbox"/> FH Psychiatric Care/Relative _____       |
| <input type="checkbox"/> FH Lung/Resp Disease/Relative _____    | <input type="checkbox"/> FH Uterine Cancer/Relative _____         |
| <input type="checkbox"/> FH Osteoporosis/Relative _____         | <input type="checkbox"/> FH Weight Disorder/Relative _____        |
| <input type="checkbox"/> FH Seizures/Relative _____             | <input type="checkbox"/> FH Other Medical Problems/Relative _____ |
| <input type="checkbox"/> FH Severe Allergies/Relative _____     | <input type="checkbox"/> FH P M S/Relative _____                  |
| <input type="checkbox"/> FH Stroke/CVA/Relative _____           | <input type="checkbox"/> FH Endometriosis/Relative _____          |
| <input type="checkbox"/> FH Thyroid Disorder/Relative _____     |   |
| <input type="checkbox"/> FH Other Cancer/Relative _____         |   |

### Social History

**Smoking Status:**       Current       Former       Never       Unknown

- |  |  |
|--|--|
| <input type="checkbox"/> Drug Use – yes    | <input type="checkbox"/> Sexually Active-Yes |
| <input type="checkbox"/> Drug Use – no     | <input type="checkbox"/> Partners-Male       |
| <input type="checkbox"/> Alcohol Use-yes   | <input type="checkbox"/> Partners-Female     |
| <input type="checkbox"/> Alcohol Use-no    | <input type="checkbox"/> Alcohol Use-no      |
| <input type="checkbox"/> Passive Smoke-yes | <input type="checkbox"/> HIV/High Risk-yes   |
| <input type="checkbox"/> Passive Smoke- no | <input type="checkbox"/> HIV/High Risk-no    |

## Urogynecology & Pelvic Surgery

<p><b>•General Complaints of:</b></p> <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Headache <input type="checkbox"/> Sweats <input type="checkbox"/> Anorexia <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness <input type="checkbox"/> Malaise <input type="checkbox"/> Weight Loss <input type="checkbox"/> Sleep Disorder	<p><b>•Eyes Complaints of:</b></p> <input type="checkbox"/> Vision Loss – 1 eye <input type="checkbox"/> Double vision <input type="checkbox"/> Eye irritation <input type="checkbox"/> Vision loss – both eyes <input type="checkbox"/> Blurring <input type="checkbox"/> Eye Pain <input type="checkbox"/> Halos <input type="checkbox"/> Discharge <input type="checkbox"/> Light sensitivity	<p><b>•ENT Complaints of:</b></p> <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Ear discharge <input type="checkbox"/> Ear ache <input type="checkbox"/> Decreased hearing <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sore Throat	<p><b>•CV Complaints of:</b></p> <input type="checkbox"/> Varicose Veins <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Difficulty breathing at night <input type="checkbox"/> Near fainting <input type="checkbox"/> Chest pain or discomfort <input type="checkbox"/> Fatigue <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Shortness of breath with no exertion <input type="checkbox"/> Palpitations <input type="checkbox"/> Swelling of hands or feet
<p><b>•Resp Complaints of:</b></p> <input type="checkbox"/> Sleep disturbances due to breathing <input type="checkbox"/> Frequent cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Chest discomfort <input type="checkbox"/> Wheezing <input type="checkbox"/> Excessive sputum <input type="checkbox"/> Excessive snoring	<p><b>•GI Complaints of:</b></p> <input type="checkbox"/> Excessive appetite <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Indigestion <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Yellowish skin color <input type="checkbox"/> Gas <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Abdominal bloating <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Diarrhea <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Constipation <input type="checkbox"/> Dark tarry stools	<p><b>•GU Complaints of:</b></p> <input type="checkbox"/> Foul urinary discharge <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Inability to empty bladder <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Kidney pain <input type="checkbox"/> Trouble starting urinary stream <input type="checkbox"/> Painful urination <input type="checkbox"/> Night time urination <input type="checkbox"/> Inability to control bladder <input type="checkbox"/> Genital sores <input type="checkbox"/> Lack of sexual drive <input type="checkbox"/> Excessive heavy periods <input type="checkbox"/> Missed Periods <input type="checkbox"/> Unusual urinary color	<p><b>•GU Complaints of:</b></p> <input type="checkbox"/> Other abnormal vaginal bleeding <input type="checkbox"/> Pelvic Pain

## Urogynecology & Pelvic Surgery

•Neuro Complaints of:	•Endo Complaints of:	•Heme Complaints of:	•Allergy Complaints of:
<input type="checkbox"/> Tremors	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Enlarged lymph nodes	<input type="checkbox"/> Persistent infections
<input type="checkbox"/> Difficulty with Concentration	<input type="checkbox"/> Cold intolerance	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Hives or rash
<input type="checkbox"/> Poor balance	<input type="checkbox"/> Heat intolerance	<input type="checkbox"/> Skin discoloration	<input type="checkbox"/> Seasonal allergies
<input type="checkbox"/> Headaches	<input type="checkbox"/> Changes in nail beds	<input type="checkbox"/> Abnormal bruising	<input type="checkbox"/> Drug allergies
<input type="checkbox"/> Disturbances in coordination	<input type="checkbox"/> Excessive urination	<input type="checkbox"/> Fevers	<input type="checkbox"/> Contact allergies
<input type="checkbox"/> Numbness	<input type="checkbox"/> Excessive thirst		<input type="checkbox"/> Food allergies
<input type="checkbox"/> Inability to speak	<input type="checkbox"/> Diabetes		<input type="checkbox"/> HIV exposure
<input type="checkbox"/> Falling down	<input type="checkbox"/> Hypothyroid		
<input type="checkbox"/> Tingling	<input type="checkbox"/> Weight change		
<input type="checkbox"/> Brief paralysis			
<input type="checkbox"/> Visual disturbances			
<input type="checkbox"/> Seizures			
<input type="checkbox"/> Weakness			
<input type="checkbox"/> Sensation of room spinning			



## Urogynecology & Pelvic Surgery

### (VISIT INFO)

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

<b>Urinary</b>	<input type="checkbox"/> Urinary Incontinence <input type="checkbox"/> Urinary burning/pain	<input type="checkbox"/> Frequent Urination <input type="checkbox"/> Frequent bladder infection	<input type="checkbox"/> Nighttime Voiding <input type="checkbox"/> Difficulty Emptying bladder	<input type="checkbox"/> Urgency to Urinate
<b>Vaginal</b>	<input type="checkbox"/> Vaginal/Uterine Prolapse <input type="checkbox"/> Vaginal Dryness	<input type="checkbox"/> Vaginal or Vulvar Pain <input type="checkbox"/> Vaginal or Vulvar itching	<input type="checkbox"/> Vaginal Bleeding	<input type="checkbox"/> Vaginal Discharge
<b>Bowel</b>	<input type="checkbox"/> Accidents involving stool	<input type="checkbox"/> Accidents involving gas	<input type="checkbox"/> Constipation	
<b>Sexual</b>	<input type="checkbox"/> Decreased Satisfaction	<input type="checkbox"/> Painful Intercourse		
<b>Other</b>	<input type="checkbox"/> Pelvic Pain <input type="checkbox"/> Back Pain	<input type="checkbox"/> Bladder Pain	<input type="checkbox"/> Rectal Pain	<input type="checkbox"/> Abdominal Pain
<b>Which ONE symptom is MOST bothersome?</b>				

## Urogynecology & Pelvic Surgery

### PROBLEMS - How long have these problems been present?

- |  |  |
|--|--|
| <input type="checkbox"/> Less than 1 month | <input type="checkbox"/> 3-5 years         |
| <input type="checkbox"/> 1-6 months        | <input type="checkbox"/> 6-10 years        |
| <input type="checkbox"/> 6-12 months       | <input type="checkbox"/> More than 10 year |
| <input type="checkbox"/> 1-2 years         |  |

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

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

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

- |  |  |
|--|--|
| <input type="checkbox"/> Improve my bladder control      | <input type="checkbox"/> Decrease daytime urination                                |
| <input type="checkbox"/> Decrease Nighttime Urination    | <input type="checkbox"/> Reduce urinary (bladder) infections                       |
| <input type="checkbox"/> Fix my prolapse (vaginal bulge) | <input type="checkbox"/> Reduce my vaginal prolapse symptoms                       |
| <input type="checkbox"/> Improve my bowel control        | <input type="checkbox"/> Reduce constipation and difficulty having bowel movements |
| <input type="checkbox"/> Improve sexual function         | <input type="checkbox"/> Reduce pain in pelvis, bladder, vagina                    |
| <input type="checkbox"/> Other _____                     |  |

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

- Less than 1 hour   
  1 hour   
  2 hours   
  3 hours   
  4 hours   
  5 hours  
 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                                       >5  
 1-2  
 3-4



## Urogynecology & Pelvic Surgery

### 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 *Not at all*    1    2    3    4    5    6    7    8    9    10 *A great deal*

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

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

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

- Normal
- Mild
- Moderate
- Severe