Dear Patient,

Welcome to our practice. Please fill out the enclosed paperwork **including the 24 hour voiding diary** and bring it with you to your appointment. Instructions for the voiding diary are included.

Team-based care is an important part of our practice. New patient visits are typically shared visits with the nurse practitioner and the urogynecologist.

Maine Medical Partners is part of a teaching institution and your care may also include a resident physician. Teaching resident physicians helps our team guide our future providers in the early stages of their careers. We may also have a medical student or student nurse practitioner working with us. Their role is more observational as a newer learner. Please let us know at the start of your visit if you would prefer to not be seen by the student learners.

We are looking forward to meeting you. Please call our office if you have any questions about your upcoming appointment.

Sincerely,

The urogynecology team at MMP Pelvic Medicine
DIRECTIONS:

From I-95 North or South/Maine Turnpike: Take I-95 North or South to Exit 46. After the tollbooth, take a right onto Skyway Drive. Follow Skyway Drive to the light. At the light, take a right. Follow to the next intersection (get in the left turn lane). At the intersection, take a left onto Jetport Plaza. Follow Jetport Plaza to the stop sign. At the stop sign, take a right (this will be Westbrook St., however there is no street sign). Follow Westbrook Street for approximately 1/2 mile to Brickhill Avenue (on left). Turn left onto Brickhill Avenue, and follow the road up the hill until you reach 100 Brickhill Avenue (the large brick castle on your left).

From I-295 North: Take I-295 Southbound to Exit 3 (Westbrook St./Airport). Take a right at the end of the exit ramp (Pape Chevrolet will be on your right) and proceed onto Westbrook Street. Follow Westbrook Street, bearing right at the stop light (Irving Gas Station will be on your left) to proceed up Westbrook Street. Follow Westbrook Street for approximately ¼ mile to Brickhill Avenue (on right). Turn right onto Brickhill Avenue and follow the road up the hill until you reach 100 Brickhill Avenue (the large brick castle on your left).

From Rte. 1 South/Scarborough: Follow Route 1 Northbound following signs for I-295. Take the exit labeled "Broadway." At the end of the "Broadway" exit ramp, bear right to proceed North on Broadway. Follow Broadway to the stop light. At the stop light, make a left turn onto Westbrook Street. Follow Westbrook Street past Pape Chevrolet to the next stop light (Irving Gas Station will be on your left). Bear right at the stop light to proceed up Westbrook Street approximately ¼ mile to Brickhill Avenue (on right). Turn right onto Brickhill Avenue and follow road up the hill until you reach 100 Brickhill Avenue (the large brick castle on your left).

From The West (Maine Mall): Follow Gorham Road Eastbound from the Maine Mall area past the Olive Garden Restaurant (on your right). At the next intersection, Gorham Road turns into Western Avenue (Young’s Furniture and Sea Dog Brewery will be on your left). Go straight through the intersection and follow Western Avenue to the next light (get into the left turn lane). At the light, take a left onto Westbrook Street. Proceed up Westbrook Street approximately ¼ mile to Brickhill Avenue (on right). Turn right onto Brickhill Avenue and follow road up the hill until you reach 100 Brickhill Avenue (the large brick castle on your left).
Pelvic Medicine Patient Information Questionnaire

Date: ________________

Name: _____________________________ Date of birth: _______________________

Home Address: _____________________________________________________________

Occupation: ______________________________________________________________

Referring Physician: ________________________________________________________

Other physicians/practitioners to whom a report should be sent:

________________________________________________________________________

________________________________________________________________________

Please give a brief history of your present problem or symptoms for which you were referred (Include the date of onset).

What previous evaluations/tests have you had for this problem?

What previous treatments have you had for this problem?
Urogynecologic Questions:

Uranination:
- Are you incontinent (involuntarily lose) your urine: Yes  No
- Does this happen with physical activity: Yes  No
- urgency? Yes  No
- without awareness? Yes  No
- constantly? Yes  No
- Are you concerned about your frequency of urination? Yes  No
  - Number of voids daytime? 
  - Number of voids nighttime? 
- Do you have painful urination? Yes  No
- Do you feel as though you completely empty your bladder? Yes  No
- Do you feel that your stream has a normal force and flow? Yes  No
- Do you have difficulty starting your stream? Yes  No
- Do you dribble urine after you stand from the toilet? Yes  No
- How many bladder (urinary tract) infections in the last year? 
- Do you do Kegel exercises? Yes  No
  - How many ounces of caffeinated beverages do you drink in a day? 
  - How many ounces of alcoholic beverages do you drink in a day? 
  - How often and/or how long: 
  - Do you take bladder control medications? Yes  No
    - What? 
  - Do you wear a pad? Yes  No
    - What type? 
    - Number per day? 

Bowel:
- Are you incontinent of stool? Yes  No
- Do you have trouble controlling flatus (gas)? Yes  No
- Do you have blood in your stool? Yes  No
- Do you need to lean forward or press on your vaginal area to evacuate your stool? Yes  No
- How often do you have a bowel movement? 
- What is the consistency of your stool? Hard  Soft  Liquid
- Do you use anything to assist your BMs? Yes  No
  - What? 

Vaginal/Uterine:
- Do you feel anything protruding from your vagina? Yes  No
- If menopausal, have you had any vaginal bleeding? Yes  No
- Are you sexually active? Yes  No
- Is sexual activity uncomfortable? Yes  No
- Do you have an abnormal vaginal discharge? Yes  No
  - If yes, describe:  


3.

**GYN HISTORY:**

Last menstrual period: ____________________________________________________________
If you are still having menses, do you have any problems: ____________________________________________________________
Do you or have you used hormone replacement therapy? If so, what and for how long?

If applicable, what is your contraception? ______________________________________

Have you had abnormal paps? Explain: __________________________________________
Do you have a history of fibroids, endometriosis or other GYN conditions?

**OBSTETRICAL HISTORY:**

<table>
<thead>
<tr>
<th>Date of pregnancy:</th>
<th>Outcome (Miscarriage, cesarean, normal?)</th>
<th>Delivery problems?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.________________</td>
<td>________________________________________</td>
<td>__________________</td>
</tr>
<tr>
<td>2.________________</td>
<td>________________________________________</td>
<td>__________________</td>
</tr>
<tr>
<td>3.________________</td>
<td>________________________________________</td>
<td>__________________</td>
</tr>
<tr>
<td>4.________________</td>
<td>________________________________________</td>
<td>__________________</td>
</tr>
</tbody>
</table>

**Medical Conditions:**

<table>
<thead>
<tr>
<th>Medical Conditions</th>
<th>Medications to treat:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.________________</td>
<td>______________________</td>
</tr>
<tr>
<td>2.________________</td>
<td>______________________</td>
</tr>
<tr>
<td>3.________________</td>
<td>______________________</td>
</tr>
<tr>
<td>4.________________</td>
<td>______________________</td>
</tr>
<tr>
<td>5.________________</td>
<td>______________________</td>
</tr>
<tr>
<td>6.________________</td>
<td>______________________</td>
</tr>
</tbody>
</table>

Other Medications, prescriptions or over-the-counter, that you use regularly: ____________________________

**Allergies:** (medication or environmental):

____________________________________________________________________________________

**Surgical Procedures:**

<table>
<thead>
<tr>
<th>Operation</th>
<th>Date</th>
<th>Hospital</th>
<th>Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.________</td>
<td>_______</td>
<td>_________</td>
<td>__________________</td>
</tr>
<tr>
<td>2.________</td>
<td>_______</td>
<td>_________</td>
<td>__________________</td>
</tr>
<tr>
<td>3.________</td>
<td>_______</td>
<td>_________</td>
<td>__________________</td>
</tr>
<tr>
<td>4.________</td>
<td>_______</td>
<td>_________</td>
<td>__________________</td>
</tr>
</tbody>
</table>

**Hospitalizations other than for surgery:**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Date</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.______</td>
<td>_______</td>
<td>_________</td>
</tr>
<tr>
<td>2.______</td>
<td>_______</td>
<td>_________</td>
</tr>
<tr>
<td>3.______</td>
<td>_______</td>
<td>_________</td>
</tr>
<tr>
<td>4.______</td>
<td>_______</td>
<td>_________</td>
</tr>
</tbody>
</table>
4.

**Home/Work:**

Occupation: ____________________________________________________________

Does your work involve heavy lifting or exertion?  
Yes  No

Highest educational level: ____________________________

Hobbies/interests: ______________________________________________________

Marital Status: ____________________________

Do you exercise regularly?  
What type of exercise: __________________________________________________

Do you or have you smoked cigarettes?  
How many per day: ____________

When did you quit? ________________________

**Family History:**

Do members of your family suffer from conditions related to their urinary or bowel function or to vaginal support?  
If so who and what was their problem? ______________________________________

What other medical conditions run in your family: ______________________________________

**Review of Systems:**  (Please check any symptoms that you currently have)

**General:**

Headaches____  Fatigue____  Anxiety____  Depression____

Glaucoma____  Weight Loss___  Weight gain____  Thyroid condition_____  

Heart/Circulation:

Chest Pain____  Palpitations___  Leg edema (swelling) _____

Poor Circulation___  Mitral Valve Prolapse ___  Heart Murmur___  Varicose Veins ___

Lungs:

Asthma____  Shortness of breath____  Cough___

Gastrointestinal:

Indigestion____  Constipation____  Diarrhea____  Ulcers____

Hemorrhoids____  Nausea/Vomiting____  Cramps or Pain____

Kidney:

Kidney stones____  Blood in urine____

Muscular / Skeletal:

Arthritis____  Difficulty walking____  Difficulty with hands____

Weakness___  Back Pain____

Other:
Voiding Diary

In preparation for your visit to our office, please complete a voiding diary over a 24 hour period. This information is very useful to us when we evaluate urinary symptoms including leakage and/or vaginal prolapse. It is important to accurately measure your fluid intake and output. Use a standard measuring cup or a urinary hat to measure your voids. You may obtain a hat at our office prior to your consult. This may avoid having a second visit to obtain this information. Please bring your completed 24 hour voiding diary with you to your appointment.

Instructions:

1. Begin recording in the morning upon awakening and continue for a full 24 hours.
2. Record separate lines for each urination or liquid consumed.
3. You may measure in milliliters (cc’s) or ounces, but be consistent. Please measure these volumes, do not estimate. Use a measuring cup to catch your urine.
4. If you leak, estimate the volume as follows:
   1. is dampness or drops
   2. is a larger squirt or true wetness
   3. is a very large leak or most of your bladder content
5. If your leak is related to an uncontrolled urge, then mark Yes for urge and indicate what you were doing when this happened (standing up, running water, coming in the door etc.)
6. If your leak is not related to urge, then mark No for urge. You can also indicate the associated activity such as cough, sneeze, bend, etc.

Sample Diary:

<table>
<thead>
<tr>
<th>Time</th>
<th>Amount/Type of Intake</th>
<th>Amount Urinated</th>
<th>Leakege</th>
<th>Urge</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 am</td>
<td></td>
<td>12 oz</td>
<td>1 drops, 2 wet 3 soaked</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6:30 am</td>
<td>8 oz coffee</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 am</td>
<td></td>
<td></td>
<td>2</td>
<td>No</td>
<td>Laughing</td>
</tr>
<tr>
<td>1:30 pm</td>
<td>6 oz</td>
<td>2</td>
<td>Yes</td>
<td></td>
<td>Running to the toilet</td>
</tr>
<tr>
<td>Time</td>
<td>Amount/Type of Intake</td>
<td>Amount Urinated</td>
<td>Leakage 1 drops, 2 wet 3 soaked</td>
<td>Urge Yes/No</td>
<td>Activity</td>
</tr>
<tr>
<td>------</td>
<td>----------------------</td>
<td>----------------</td>
<td>--------------------------------</td>
<td>-------------</td>
<td>----------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>