WOMEN'S PELVIC RESTORATIVE CENTER

Ginger N. Cathey, MD
7900 Fannin, Suite 4000
Houston, TX 77054
713-512-7800 Appointments/ Information
713-512-7823 Office

Date of Appointment: _____ **Time:** _____

Dear Patient,

Welcome to our practice. This letter is to confirm your appointment. Please arrive 30 minutes prior to your appointment. You must visit the check-in desk first. Please bring a copy of your insurance card. All co-payments are due at the time of each visit. If you have any questions or concerns prior to your visit, please do not hesitate to call our office.

The evaluation of pelvic floor dysfunction requires a time commitment. This is not something that can be accomplished in one visit. Usually a minimum of three to five visits are required. Therefore, we have already scheduled your next consultation visit. You may require additional tests prior to this consultation

We have taken great care to try to minimize the number of visits required partly by providing you with the enclosed forms. This allows you to collect the needed medical information at your leisure and reduces the number of visits required to address your condition. We realize the information requested is lengthy and comprehensive. You may find that you need a family member, friend, or information from your doctor to help you complete these documents. PLEASE BRING THE **COMPLETED** FORMS TO YOUR SCHEDULED VISIT. Enclosed you will find:

1. Urinary and prolapse history forms
2. Medical history forms
3. Bladder Diary (instructions attached)

In addition, if you have had previous pelvic surgery, please attempt to bring a copy or have a copy of the OPERATIVE REPORT(S) sent to us from your surgeon or the hospital where your surgery was performed. If you have had recent bladder infections, please provide us with copies of your urine cultures.

We will review these forms with you at your visit. This information is very important for the proper evaluation of your condition. Not having this information may result in a need for additional visits.

What to expect at your first visit:

Because we will perform a physical examination, we suggest that you wear comfortable clothing that is easily removed. At this initial visit, we will perform a pelvic examination that includes a catheterization and measurement of your pelvic organs to help us determine your pelvic support. The examination is not typically any more uncomfortable than other pelvic exams but may take longer to perform. Please do not be distressed if you do not understand our conversation during your examination as we will explain this to you following your exam.

After your examination, we will ask you to dress and we will discuss with you our findings and recommendations. In most instances, we cannot make final treatment recommendations without further testing but we will give you information about your condition for you to take home and read. This will allow you to become more familiar with the information that we may discuss at future visits. This information is your ***homework***. It is extremely important that you become familiar with this information in order to understand the implications of your condition as well as risks, benefits and expectations regarding treatment options.

If your circumstances are different and you wish only to have a visit for a discussion consultation without an evaluation, please let our nurse know.

As a courtesy to the staff and to other patients, we ask that you give us 24 hours notice if you must cancel or reschedule your appointment. Additionally, appointments are for a specific time frame. Please respect the time of other patients. If you feel that additional time is needed to discuss your health condition, please arrange for a follow-up appointment.

Again, if you have any questions prior to your visit, please do not hesitate to call. We look forward to meeting you.

Sincerely,

Dr. Ginger Cathey &
Staff of Women's Pelvic Restorative Center

WOMEN'S PELVIC RESTORATIVE CENTER

Ginger N. Cathey, MD
Urogynecology
7900 Fannin St., Suite 4300
Houston, TX 77054

Name: _____

Date of Appointment: _____ Date of Birth: _____

Date Completed: _____ Age: _____

Reason for visit: _____

_____

_____

Please provide name, address and **fax** or phone number for the following physicians or healthcare providers:

Who referred you to us? _____

_____

Who is your primary care physician? _____

_____

Who is your regular gynecologist? _____

_____

Do you see any specialists?

Name, address, phone number

Gastroenterologist _____

Cardiologist _____

Urologist _____

Colorectal Surgeon _____

Other _____

Revised: 03/2015

HISTORY

URINARY INCONTINENCE

Yes	No	
Y	N	Do you have accidental loss of urine?
_____		How many months or years have you had leakage of urine?
Y	N	Do you wear pads to absorb lost urine?
_____		If yes, what size pad do you wear?
_____		How many pads do you wear in a day?
_____		How many trips to the bathroom do you make during the day from the time you wake up in the morning until the time you go to sleep at night?
Y	N	Does an uncomfortably strong need to pass urine wake you up?
_____		How many times are you awakened during the night after going to sleep by an urge to urinate?
Y	N	Does the sound, sight or feel of running water cause you to lose urine?
Y	N	Do you lose urine during the act of intercourse at penetration?
Y	N	Do you lose urine during orgasm?
Y	N	I lose urine during coughing, sneezing, running or heavy lifting
Y	N	I lose urine with changes in posture, standing or walking
Y	N	I lose urine continuously such that I am constantly wet
Y	N	Have you seen a physician for complaints of urine loss?
Y	N	Have you taken medicine to prevent urine loss? If yes, name the medication _____
Y	N	Have you had surgery to prevent urine loss? If yes, was it done through the vagina? Was it done through the abdomen?
Y	N	Do you notice any dribbling or urine when you stand after passing your urine?
Y	N	Do you usually have difficulty starting your urine stream?

Y N Have you ever required catheterization for the inability to pass your urine?

Y N Do you always feel that your bladder is empty after passing urine?

Y N Have you seen any blood in your urine?

Y N Do you have any burning with urination?

Y N Have you had 3 or more urinary tract infections in the last year?

GENITOURINARY PROLAPSE

Y N Do you have a bulge or mass in your vagina:

_____ How many months or years have you had this bulge or mass?

Y N Have you seen a doctor for this bulge or mass in your vagina?

Y N Have you worn a pessary for this problem?

_____ If yes, how many months or years have you worn this pessary?

Y N Have you had surgery in the past for a bulge or mass in the vagina?

FECAL INCONTINENCE

Y N Do you have accidental loss of solid stool?

Y N Do you have accidental loss of liquid stool?

Y N Do you have accidental loss of gas?

___yr___mo How many months or years have you had accidental loss of stool or gas?

Y N Have you seen a doctor for this problem?

Y N Did the problem with accidental loss of stool begin after childbirth?

Y N Do you wear protective pads for this problem?

_____ If yes, what size pad do you wear?

_____ How many pads do you wear each day?

Y N Are you able to sense the need to have a bowel movement?

Y N Are you able to tell the difference between solid stool/liquid stool/gas?

Y N Do you have a frequent desire to have a bowel movement?

Y N Have you had surgery for this problem?

Y N Has there been a change in your bowel habits recently?

Y N Have you noticed any bright red bleeding with your bowel movements?

Y N Have you noticed black or "tarry" stools?

Y N Are your bowel movements painful?

CONSTIPATION

Y N Do you have constipation?

Y N Do you excessively strain to pass stool more than 25% of the time?

Y N Do you have at least three bowel movements each week?

_____ How many bowel movements do you have each week?

Y N Do you pass hard, small stool?

__yr___mo How many months or years have you had constipation?

Y N Have you seen a doctor for this problem?

Y N Do you use any medication or over the counter products for this?
If yes, what have you used? _____

Y N Have you had surgery for this problem?

Y N Have you ever placed your hand or fingers in your vagina or between your vagina and rectum to help bring about a bowel movement?

Y N Do you have a feeling of incomplete emptying after bowel movements?

Y N Have you had a colonoscopy? Date: _____ Results: _____

PAST GYN HISTORY

Last pap test (month & year): _____
Have you ever had an abnormal pap smear? Yes No If yes, what year? _____
Last mammogram (month & year): _____
Have you ever had an abnormal mammogram? Yes No If yes, what year? _____

Y N Have you gone through menopause?
If yes, at what age did you go through menopause? _____

Y N Are your periods regular? How many days do you bleed?_____
Y N Have you had any vaginal bleeding or spotting since menopause?

Y N Have you had a hysterectomy?

If yes, was it done through the vagina or abdomen or laparoscopically ? (Please circle)

Y N Do you have your ovaries?
If yes, both or only one (Please circle)

Y N Have you had surgery for leakage of urine?

Y N Have you had surgery for prolapse, "bulges" or "fallen pelvic organs"?

PAST OBSTETRICAL HISTORY

Number of Pregnancies _____
Number of Vaginal Births _____
Number of C-Sections _____
Weight of Largest Baby _____

SEXUAL HISTORY

Y N Sexually Active? If no, why? Please circle

1. No partner
2. Partner factor
3. Loss of sex drive
4. Painful intercourse
5. Because of bulge or leak symptoms
6. Other

Partner: Male Female Both (Please circle)

Y N Contraception? If yes, please circle

1. Tubal ligation
2. Birth control pills
3. Intrauterine device IUD
4. Diaphragm
5. Depo-provera
6. Barrier
7. Postmenopausal
8. Other

Y N Pain with intercourse: If yes, please circle one or both

1. Near vaginal opening
2. Inside abdomen/pelvic area

SURGERIES / HOSPITALIZATIONS

Date(s) and reason(s) for surgery/hospitalization:

_____

_____

_____

_____

Y N Any problems with anesthesia during any surgeries?

Explain? _____

PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the following?

Y	N	Asthma	Y	N	Skin problems
Y	N	Pneumonia	Y	N	Liver problems
Y	N	Lung disease	Y	N	Thyroid disease
Y	N	Kidney problems	Y	N	Gastric Reflux
Y	N	Tuberculosis	Y	N	Psychiatric illness
Y	N	Venereal disease	Y	N	Cancer
Y	N	Heart trouble/murmur	Y	N	Ulcers
Y	N	Diabetes	Y	N	Depression/anxiety
Y	N	High blood pressure	Y	N	Seizures /epilepsy
Y	N	Stroke	Y	N	Bowel trouble
Y	N	Migraine Headaches	Y	N	Glaucoma
Y	N	Blood disorders	Y	N	Arthritis/joint pain
Y	N	Transfusions	Y	N	Fracture
Y	N	Drug or alcohol abuse	Y	N	Hepatitis / AIDS
Y	N	Muscle or bone problems	Y	N	High Cholesterol
Y	N	Chronic pain	Other _____		

INJURIES/ILLNESSES

Date(s) and description(s) of injuries and/or illnesses:

_____

_____

_____

_____

_____

FAMILY HISTORY

Has a **blood-related** family member had any of these illnesses:

Yes	No	Don't Know		Relationship
Y	N	?	Diabetes	_____
Y	N	?	Stroke	_____
Y	N	?	Heart disease	_____
Y	N	?	High blood pressure	_____
Y	N	?	Breast cancer	_____
Y	N	?	Colon cancer	_____
Y	N	?	Ovarian cancer	_____
Y	N	?	Prolapse	_____
Y	N	?	Urinary incontinence	_____
Y	N	?	Fecal incontinence	_____

PERSONAL AND SOCIAL HISTORY

Who lives in your home with you? _____
Current marital status: Married _____ Divorced _____ Single _____ Widowed _____

Ethnic Background: Caucasian _____ African-American _____
Hispanic _____ Asian_____ Other _____

Y N Are you employed? If so, occupation: _____

Y N Does your job or a hobby require heavy physical work?

Education

Level of Education: _____ Up to 12th Grade _____ Beyond 12th Grade

Personal Habits

Y N Smoking Packs per day: _____ Years of use: _____

Y N Alcohol Drinks per day: _____ Drinks per week: _____

Y N Recreational Drug Use What type?_____ How often?_____

MEDICATIONS / PRODUCTS / HERBALS

(Please bring medications in the original bottles for us to review if not recorded)

NAME	DOSAGE	HOW OFTEN

ALLERGIES

	Symptoms:
	Symptoms:
	Symptoms:
	Symptoms:
	Symptoms:
	Symptoms:

REVIEW OF SYSTEMS

Please check appropriate box if any of the following apply to you and these are problems that have not been evaluated prior. If checked, please explain.

			NOTES
1.	**Constitutional**		
	Weight loss	☐	_____
	Weight gain	☐	_____
	Fever/ Chills	☐	_____
	Fatigue	☐	_____
2.	**Eyes**		
	Double vision	☐	_____
	Spots before eyes	☐	_____
	Vision changes	☐	_____
3.	**ENT/Mouth**		
	Ear aches	☐	_____
	Sinus problems	☐	_____
	Sore throat	☐	_____
	Mouth sores	☐	_____
	Dental problems	☐	_____
4.	**Cardiovascular**		
	Chest pain	☐	_____
	Difficult breathing on exertion	☐	_____
	Swelling of legs	☐	_____
	Palpitations of heart	☐	_____
5.	**Respiratory**		
	Wheezing	☐	_____
	Spitting up blood	☐	_____
	Shortness of breath	☐	_____
	Chronic cough	☐	_____
6.	**Gastrointestinal**		
	Abdominal Pain	☐	_____
	Blood in stool	☐	_____
	Nausea/vomiting	☐	_____
7.	**Musculoskeletal**		
	Muscle weakness	☐	_____
	Joint pain	☐	_____
	Back pain	☐	_____

REVIEW OF SYSTEMS - Continued

NOTES

8. Skin/Breast

Pain in breast	☐	_____
Discharge	☐	_____
Masses	☐	_____
Rash	☐	_____
Ulcers	☐	_____

9. Neurological

Dizzy spells	☐	_____
Seizures	☐	_____
Numbness/ tingling	☐	_____
Trouble walking	☐	_____

10. Psychiatric

Depression	☐	_____
Frequent Crying	☐	_____
Thoughts of Suicide	☐	_____

11. Endocrine

Dry skin	☐	_____
Abnormal thirst	☐	_____
Hot flashes	☐	_____

12. Hematologic/lymphatic

Frequent bruises	☐	_____
Cuts that don't stop bleeding	☐	_____
Enlarged lymph nodes	☐	_____

13. Allergic/immunologic

Allergies	☐	_____
Drug/ Latex allergies	☐	_____

Please list any other concerns you may have regarding your medical history and care.

_____

_____

Completed by: Patient ☐ Family Member ☐ Office Nurse ☐ Physician ☐

Signature of patient: _____

Date reviewed by physician with patient: _____

Physician signature: _____

Revised: 09/10/12 GNC

WOMEN'S PELVIC RESTORATIVE CENTER

Ginger N. Cathey, M.D.
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Houston, TX 77054
713-512-7800 (Main) •713-512-7873 (Fax)

VOIDING DIARY (UROLOG)

THIS CHART IS A RECORD OF YOUR VOIDING (URINATING) AND LEAKAGE (INCONTIENCE) OF URINE. PLEASE READ THE DIRECTIONS CAREFULLY AND **COMPLETE THIS SHEET PRIOR TO YOUR FIRST APPOINTMENT.** CHOOSE A 24 HOUR PERIOD TO KEEP THIS RECORD WHEN YOU CAN MEASURE EVERY VOID. START THE CHART WITH THE FIRST VOID WHEN YOU GET UP IN THE MORNING.

WE REALIZE THIS MAY BE AN INCONVENIENCE, BUT THE INFORMATION IT PROVIDES IS VERY IMPORTANT IN ASSESSING YOUR BLADDER PROBLEM. WE MAY HAVE TO RESCHEDULE YOUR APPOINTMENT IF THIS DIARY IS NOT AVAILABLE AT YOUR FIRST APPOINTMENT.

YOU MAY MEASURE AMOUNTS IN OUNCES OR IN CC'S-BUT PLEASE INDICATE WHICH YOU ARE USING.

NOTE: 1 CUP = 8 OUNCES = 240 CC'S

1. TIME — Record time of every time you void. leak or drink.

2. AMOUNT VOIDED — Measure and write down amount of urine voided.

3. ACTIVITY — Write down what you were doing when you leaked or lost control of your bladder. Examples are: getting out of a chair, bending over, vacuuming, gardening, doing dishes, taking shower, etc. If you were NOT doing anything active, write down whether you were standing, sitting or lying down.

4. AMOUNT LEAKED — Estimate the amount you leaked according to this scale:

   1 = damp, few drops only.
   2 = wet underwear or pad.
   3= soaked pad or clothing or bladder emptied completely.

5. URGE PRESENT — If you had an urge to void before or at the time of the leakage write YES. If there was NO urge or you didn't realize you were voiding write NO

6. AMOUNT AND — Measure and write down the amount and type of all liquids you drink.

NAME: _____

VOIDING DIARY (UROLOG)

TIME	AMOUNT VOIDED	ACTIVITY	AMOUNT LEAKED	URGE PRESENT	AMOUNT AND TYPE OF FLUID
6:45 am	500 cc	Waking up		No	
7:00 am		Turned on water	2	Yes	1 cup of coffee 8 oz orange juice

Revised: 03/2015

NAME: _____ DATE: _____

Do you experience, and if so, how much are you bothered by:	Not at All	Slightly	Moderately	Greatly
1. Urine leakage related to the feeling of urgency 2. (sudden desire to urinate)?	0	1	2	3
3. Urine leakage related to physical activity, 4. coughing, or sneezing?	0	1	2	3
5. Small amounts of urine leakage (drops)?	0	1	2	3
6. Difficulty emptying your bladder?	0	1	2	3
7. Pain or discomfort in the lower abdominal or genital area?	0	1	2	3

Urogenital Distress Inventory-Short form

UDI-6 Scoring. Item responses are assigned values of 0 for "not at all," 1 for "slightly," 2 for "moderately," and 3 for "greatly." The average score of items responded to is calculated. The average, which ranges from 0 to 3, is multiplied by 33 1/3 to put scores on a scale of 0 to 100.

Quality of life due to urinary problems

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that? **Please draw an "X"** across the scale below to best reflect your feelings about your urinary problem.

Pleased Terrible

|_____|_____|_____|_____|_____|_____|

Some people find that accidental urine loss may affect their activities, relationships, and feelings. The questions below refer to areas in your life that may have been influenced or changed by your problem. For each question, circle the response that best describes how much your activities, relationships, and feelings are being affected by urine leakage.

Has urine leakage affected your...	Not at All	Slightly	Moderately	Greatly
1. Ability to do household chores (cooking, house cleaning, laundry)?	0	1	2	3
2. Physical recreation such as walking, swimming, or ot exercise?	0	1	2	3
3. Entertainment activities (movies, concerts, etc.)?	0	1	2	3
4. Ability to travel by car or bus more than 30 minutes from home?	0	1	2	3
5. Participation in social activities outside your home?	0	1	2	3
6. Emotional health (nervousness, depression, etc.)?	0	1	2	3
7. Feeling frustrated?	0	1	2	3

Incontinence Impact Questionnaire– Short Form IIQ-7

NAME: _____ **DATE:** _____

These questions ask about symptoms you may have related to urine leakage. Please circle the number that represents how frequently you experience each symptom.

	0 Never	1 Rarely	2 Sometimes	3 Often
Does coughing gently cause you to lose urine?				
Does coughing hard cause you to lose urine?				
Does sneezing cause you to lose urine?				
Does lifting things cause you to lose urine?				
Does bending cause you to lose urine?				
Does laughing cause you to lose urine?				
Does walking briskly or jogging cause you to lose urine?				
Does straining, if you are constipated, cause you to lose urine?				
Does getting up from a sitting to a standing position cause you to lose urine?				
Some women receive very little warning and suddenly find that they are losing, or are about to lose, urine beyond their control. How often does this happen to you?				
If you can't find a toilet or find that the toilet is occupied, and you have an urge to urinate, how often do you end up losing urine or wetting yourself?				
Do you lose urine when you suddenly have the feeling that your bladder is very full?				
Does washing your hands cause you to lose urine?				
Does cold weather cause you to lose urine?				
Does drinking cold beverages cause you to lose urine?				

MESA Questionnaire

NAME:_____ **DATE:** _____

Instructions:
Please answer these questions by putting a **X** in the appropriate box. If you are unsure about how to answer a question, give the best answer you can. While answering these uestions, please consider your symptoms over the **last 3 months.** Thank you for your help.

		Not at all	Somewhat	Moderately	Quite a bit
1. Do you usually experience *pressure* in the lower abdomen?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	1	2	3	4
2. Do you usually experience *heaviness or dullness* in the pelvic area?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	1	2	3	4
3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	1	2	3	4
4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	1	2	3	4
5. Do you usually experience a feeling of incomplete bladder emptying?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	1	2	3	4
6. Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	1	2	3	4
7. Do you feel you need to strain too hard to have a bowel movement?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	1	2	3	4
8. Do you feel you have not completely emptied your bowels at the end of a bowel movement?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	1	2	3	4
9. Do you usually lose stool beyond your control if your stool is well formed?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	1	2	3	4
10. Do you usually lose stool beyond your control if your stool is loose or liquid?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	1	2	3	4

Revised: 03/2015

NAME: _____

		Not at all	Somewhat	Moderately	Quite a bit
11. Do you usually lose gas from the rectum beyond your control?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	1	2	3	4
12. Do you usually have pain when you pass your stool?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	1	2	3	4
13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	1	2	3	4
14. Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	1	2	3	4
15. Do you usually experience frequent urination?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	1	2	3	4
16. Do you usually experience urine leakage associated with a feeling of urgency that is a strong sensation of needing to go to the bathroom?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	1	2	3	4
17. Do you usually experience urine leakage related to coughing, sneezing, or laughing?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	1	2	3	4
18. Do you usually experience small amounts of urine leakage (that is, drops)?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	1	2	3	4
19. Do you usually experience difficulty emptying your bladder?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	1	2	3	4
20. Do you usually experience *pain* or *discomfort* in the lower abdomen or genital region?	❑ No → *Go to next question* ❑ Yes→ how much does this bother you? →	1	2	3	4