WOMEN'S PELVIC RESTORATIVE CENTER

713-512~7800

Kimberly Miller-Miles, M.D.

251 Medical Center Blvd., Suite 230

Webster, Texas 77598

713-578-3860 (Main) • 281-338-2982 (Fax)

PelvicRestorativeCenter.com

Date: _____

Dear: _____

Welcome to the Women's Pelvic Restorative Center–Bay Area. This letter is to confirm your appointment with Dr. Kimberly Miller-Miles at the Women's Pelvic Restorative Center-Bay Area office. Our office is located at 251 Medical Center Blvd. ~ Suite 230 (2nd Floor), Webster, Texas 77598.

*Please plan to **arrive <u>30 minutes prior to your appointment.</u>**

If you take an antibiotic before you go to the dentist or if you have an artificial heart valve, a catheter or a pacemaker please contact your <u>regular</u> doctor for his/her advice on the necessity of taking an antibiotic before we see you.

Please take a few minutes to review the enclosed papers. PLEASE BRING THE COMPLETED PATIENT PACKET TO YOUR FIRST SCHEDULED APPOINTMENT - YOU MAY KEEP THE FIRST PAGE FOR YOUR RECORDS. Several appointments have been made for you and are listed on the back of this sheet. Not all patients need all appointments, but it is easier to cancel one than to add one in a pinch. Please note that we may have to reschedule your appointment if your paperwork is not completed at the time of your first visit. Enclosed you will find:

1. Medical history - 2 pages front and back
2. **<u>24 hour</u>** voiding diary - directions on one side, blank to complete on the other side
3. Voiding questionnaire - One page front and back

In addition, please bring the following:

1. A copy of your most recent mammogram report (not the actual x-ray film)
2. **If you have had previous pelvic surgery, please have a copy of the <u>OPERATIVE REPORT</u> sent to us** from your surgeon or the hospital where it was performed. There is more than one surgical procedure that can be done to correct urinary incontinence or a bulge. Not knowing the exact name of the surgery that you had can potentially limit our ability to assist you.
3. **Please bring your insurance card**. All <u>co-payments</u> are due at the time of each visit.

Over

Revised: 01/2015

In order to devote full attention to you, we do not "double book" patients or appointments. Therefore, as a courtesy to our staff and to other patients, we kindly 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 have reached the conclusion of your appointment time and need additional time to discuss your health condition, we will be pleased to arrange for a follow-up appointment.

Thank you for your attention to these matters. Please feel free to call should you have any questions prior to your visit. We look forward to meeting you.

Sincerely,

Kimberly Miller-Miles, MD and the Staff of the Women's Pelvic Restorative Center-Bay Area

APPOINTMENTS

Part I (30-45 minutes): _____
Part II (30 minutes): _____
Part III (60 minutes): _____
Consult (45 minutes): _____

We would like to thank you for the opportunity to serve you.

WPRC Health Care Providers:
Peter M. Lotze, M.D.
Ginger N. Cathey, M.D.
Kimberly R. Miller-Miles, M.D.
Hilaire W. Fisher, M.D.

WOMEN'S PELVIC RESTORATIVE CENTER

URINARY INCONTINENCE IN WOMEN

Urinary incontinence is a common condition. An estimated 15-30% of women experience incontinence. Although it should never be considered normal, it is significantly more common in elderly women and even more common in nursing home patients. (Men also experience urinary incontinence, but much less frequently than women and it usually occurs following radical surgery or with other neurologic disorders).

TYPES OF URINARY INCONTINENCE

The two most common types of incontinence are stress urinary incontinence and urge incontinence. Both of these types of incontinence can be effectively treated using a combination of behavior modification techniques and pelvic floor muscle exercises. Other therapy options include surgical correction for stress urinary incontinence and pharmacologic therapy for Detrusor Instability ("overactive bladder").

Stress urinary incontinence in the majority of cases is due to a loss of support to the urethra, which is the structure that carries the urine from the bladder to the outside of the body. When there is a loss of support to the urethra, urine loss can occur during activities that increase abdominal pressure (i.e. cough, sneeze, aerobic exercise, lifting, etc.). Causes of this loss of urethral support include: childbirth, which may change the structure supports of the urethra and may be the cause of pelvic floor nerve damage; chronic cough; constipation; and other conditions which tend to create chronically increased pressures within the abdomen.

Urge incontinence is the loss of urine associated with an involuntary and uncontrollable urge to urinate. Urge incontinence occurs when the bladder muscle becomes overactive and no longer responds to normal reflex, and/or central (brain) commands telling the bladder to relax. This bladder hyperactivity is called Detrusor Instability if there is no evidence of any underlying neurologic disorder. The cause of this condition is unknown. Many neurological conditions such as a stroke, Parkinson's disease, and Multiple Sclerosis can lead to similar complaints of urge incontinence.

TREATMENT OPTIONS

Numerous treatment options are available for our patient's complaint(s). Appropriate options are identified through patient assessment. Options available to patients for their complaint(s) based on their findings may include (but are not limited to) the following services offered through our clinic:

- Pessaries for urinary incontinence
- Pessaries for pelvic support problems
- Kegel exercise instruction
- Biofeedback
- Lifestyle modification for urinary incontinence
- Bladder retraining drills / voiding schedules
- Medication management for incontinence
- Therapy for inflammatory states of the bladder
- Surgery for pelvic support problems
- Surgery for stress incontinence
- Coordination with other support services for multiple medical complaints (including colorectal surgery, certified nutritionist assessment, and physical therapy)

WOMEN'S PELVIC RESTORATIVE CENTER

Kimberly Miller-Miles, M.D.

251 Medical Center Blvd., Suite 230

Webster, Texas 77598

713-578-3860 (Main) •281-338-2982 (Fax)

Who referred you to our office?

- ☐ **Myself**
- ☐ **A friend/family member** _____
- ☐ **Doctor / Health Care Provider:** _____

(Please include his / her phone number)

Please list the name(s) of your physician(s) and their office address(es).

Physician Name	Specialty	Office Address	Office Phone	Fax

MEDICAL HISTORY QUESTIONNAIRE

DIRECTIONS: Please read and complete. Thank you.

Name: _____ Date Completed: _____
Age: _____ Birth Date: _____

Please write down why you are coming for this evaluation and what results you would like to have.

_____
_____
_____
_____
_____

Please fill in the following information in the blanks provided.

Obstetric

Number of: Pregnancies: _____ Number of vaginal deliveries: _____
Number of caesarean sections: _____ Miscarriages:_____ Abortions:_____
Current birth control method: _____

Gynecology

Age when periods started _____ Date of last period _____ Are your periods regular? Yes / No
Number of days from start of one period to next _____ How long does your period last? _____

Have you gone through menopause? Yes / No
If Y (yes), at age _____ Reason for menopause: Natural ____ Hysterectomy _____
Have you had any bleeding since menopause? No ____ Yes ____

Do you have any of the following?
❑ Bleeding between periods For how long? _____
❑ Bleeding after intercourse For how long? _____
❑ Heavy menstrual periods For how long? _____

Date of last Pap smear? _____ Results? _____
Where was Pap smear done? _____

DES exposure? No _____ Yes _____
(DES is a drug your mother would have taken to prevent her from having a miscarriage. You would have been exposed to DES while she was pregnant with you.)

Have you had any treatment to your cervix? Y / N (if Yes, please indicate below)
❑ Cautery Date _____ Reason _____
❑ Cryosurgery Date _____ Reason _____

❑ Other _____ Date _____ Reason _____

Gynecology (continued)

Please circle if you had any of the following: (if Yes, please give date)

Infection in your female organs? Y / N Date _____
Venereal Disease? Y / N Date _____
Herpes? Y / N Date _____

Please answer.

Are you sexually active? Y / N
Is your sex life satisfactory to you? Y / N

Date of last mammogram? _____ Result _____
Where was your mammogram done? _____

Past Medical History

As an adult have you had any of the following: (if yes, please check)

❑ Heart Disease ❑ Kidney Disease ❑ Kidney Infection ❑ Diabetes
❑ Liver Disease ❑ Tuberculosis ❑ High Blood Pressure ❑ Neurological disease
❑ Asthma / COPD ❑ Jaundice ❑ Thyroid disease ❑ Stroke
❑ Mitral Valve Prolapse
❑ Other _____
❑ Other _____

Past Surgical History

Have you had any operations Y/ N (If yes, please list below)

Surgery Month/Year (or your age at the time of surgery) Complications (if any)

_____
_____
_____
_____
_____
_____

Have you ever had a blood transfusion? Yes / No
If Yes, did you have a reaction? Yes / No

Medicines

Do you do any of the following?

Smoke Y / N If yes, how many packs per day? _____ How long? _____
Use Alcohol? Y / N
Use street drugs? Y / N
Have drug allergies? Y / N If yes, please list _____

Please list **all** medications **(AND DOSES)** you are currently taking, including vitamins and contraceptives.

_____

_____

_____

_____

Family History

Please check if anyone in your family has/had these diseases and list relationship.

- ❑ High blood pressure Relationship _____
- ❑ Stroke Relationship _____
- ❑ Heart disease Relationship _____
- ❑ Diabetes Relationship _____
- ❑ Breast cancer Relationship _____
- ❑ Other cancer Relationship _____
- ❑ Other Relationship _____
- ❑ Other Relationship _____

Social History Please answer.

Current marital status: _____
Number of people living in your household: _____
Your occupation: _____
Spouse's occupation: _____

Health Habits Please answer.

How many hours do you sleep at night? _____

Do you eat regular meals, including breakfast? _____

Do you eat whole grain bread and cereal, fresh fruits and vegetables daily? _____

Do you exercise regularly? _____

If yes, what type of exercise? _____

How often? _____

What do you do to relax? _____

Do you consider yourself healthy? _____

Review of Systems Please indicate if you have had any of the following RECENTLY. Circle Yes or No. If Yes, please explain. **Please circle "Yes" OR "No" for each response. We will not be able to see you until every question has been circled Yes or No. NO EXCEPTIONS.**

Constitutional Symptoms .
Fever Y / N
Chills Y / N
Headache Y / N
Other _____

Eyes
Blurred Vision Y / N
Double Vision Y / N
Pain Y / N
Other _____

Allergic/Immunologic
Hay Fever Y / N
Drug Allergies Y / N
Other _____

Neurological
Tremors Y / N
Dizzy spells Y / N
Numbness/tingling Y / N
Other _____

Endocrine
Excessive thirst Y / N
Too hot/cold Y / N
Tired/sluggish Y / N
Other _____

Gastrointestinal
Abdominal pain Y / N
Nausea/vomiting Y / N
Indigestion/heartburn Y / N
Other _____

Cardiovascular
Chest pain Y / N
Varicose veins Y / N
High blood pressure Y / N
Other _____

Integumentary
Skin Rash Y / N
Boils Y / N
Persistent Itch Y / N
Other _____

Musculoskeletal
Joint Pain. Y / N
Neck Pain Y / N
Back Pain Y / N
Other _____

Ear/Nose/Throat/Mouth
Ear Infection Y / N
Sore Throat Y / N
Sinus Problems Y / N
Other _____

Genitourinary
Urine retention Y / N
Painful urination Y / N
Urinary frequency Y / N
Other _____

Respiratory
Wheezing Y / N
Frequent cough Y / N
Shortness of breath Y / N
Other _____

Hematologic/Lymphatic
Swollen glands Y / N
Blood clotting problem Y / N
Other _____

Psychologic
Are you generally satisfied with your life? Y / N
Do you feel severely depressed Y / N
Have you considered suicide? Y / N

Physician use only: (Comment/Notes)

MD/Date: _____

# Answer	Level of Service
0-1	1 or 2
2-9	3
>10	4 or 5

WOMEN'S PELVIC RESTORATIVE CENTER

Kimberly Miller-Miles, M.D.
251 Medical Center Blvd., Suite 230
Webster, Texas 77598
713-578-3860 (Main) •281-338-2982 (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 TYPE OF FLUID — Measure and write down the amount and type of all liquids you drink.

Revised: 01/2015

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: 01/2015

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:_____

Gas / Stool Leakage (Incontinence)

Please answer all of the questions in the following survey:

These questions will ask you if you have certain bowel symptoms and if you do how much they bother you.

Answer these questions by circling the appropriate box or boxes. If you are unsure about how to answer a question, give the best answer you can.

While answering these questions, please consider your symptoms over the last 3 months.

Rectal/Anal Incontinence type	**Never**	**Rarely** *Less than once a month*	**Sometimes** *Less than once a week but more than once a month*	**Usually** *Less than once a day but more than once a week*	**Always** *Once a day or more*
Solid Stool	0	1	2	3	4
Liquid Stool	0	1	2	3	4
Gas	0	1	2	3	4
Wears Pad	0	1	2	3	4
Lifestyle Alterations	0	1	2	3	4

Wexner FI Questionnaire

Pelvic Organ Prolapse / Urinary Incontinence Sexual Function Questionnaire (PISQ-12)

Instructions: Following are a list of questions about you and your partner's sex life. All information is strictly confidential. Your confidential answers will be used only to help doctors understand what is important to patients about their sex lives. Please check the box that best answers the question for you. While answering the questions, consider your sexuality over the past six months. Thank you for your help.

1. How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex, felling frustrated due to lack of sex, etc.	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
2. Do you climax (have an orgasm) when having sexual intercourse with your partner?	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
3. Do you feel sexually excited (turned on) when having sexual activity with your partner?	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
4. How satisfied are you with the variety of sexual activities in your current sex life?	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
5. Do you feel pain during sexual intercourse?	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
6. Are you incontinent of urine (leak urine) with sexual activity?	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
7. Does fear of incontinence (either stool or urine) restrict your sexual activity?	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
8. Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum or vagina falling out?)?	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
9. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
10. Does your partner have a problem with erections that affects your sexual activity?	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
11. Does your partner have a problem with premature ejaculation that affects your sexual activity?	Always ☐	Usually ☐	Sometimes ☐	Seldom ☐	Never ☐
12. Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?	Much less of the time ☐	Less intense ☐	Same intensity ☐	More intense ☐	Much more intense ☐

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

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

NAME: _____ **DATE:** _____

PLEASE REFER TO THE BACK OF THIS PAGE FOR INSTRUCTIONS ON HOW TO COMPLETE THIS FORM.
Pelvic Floor Impact Questionnaire – short form 7

How do symptoms or conditions related to the following usually affect your….	***Bladder or urine***	***Bowel or rectum***	***Vagina or Pelvis***
1. Ability to do household chores (cooking, house cleaning, laundry)?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
2. Physical recreation such as walking, swimming, or other exercise	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
3. Entertainment activities (movies, concerts, etc.)?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
4. Ability to travel by car or bus more than 30 minutes from home?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
5. Participation in social activities outside your home?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
6. Emotional health (nervousness, depression, etc.)?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
7. Feeling frustrated?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit

Revised: 01/2015

INSTRUCTIONS

Some women find that bladder, bowel or vaginal symptoms affect their activities, relationships, and feelings. For each question, place an **X** in the response that best describes how many your activities, relationships or feelings have been affected by your bladder, bowel or vaginal symptoms or conditions **over the last 3 months**. You may or may not have symptoms in each of these three areas, but please be sure to mark an answer in **all 3 columns** for each question. If do not have symptoms in one of these areas, then the appropriate answer would be "Not at all" in the corresponding column for each question.

EXAMPLE

For the following question:

If your bladder symptoms interfere with your ability to drive a car *moderately*, and your bowel symptoms interfere with your ability to drive a car *somewhat*, but your vaginal or pelvic symptoms do not interfere with your ability to drive a car or you have no vaginal or pelvic symptoms then you should place an X in the corresponding boxes as indicated below:

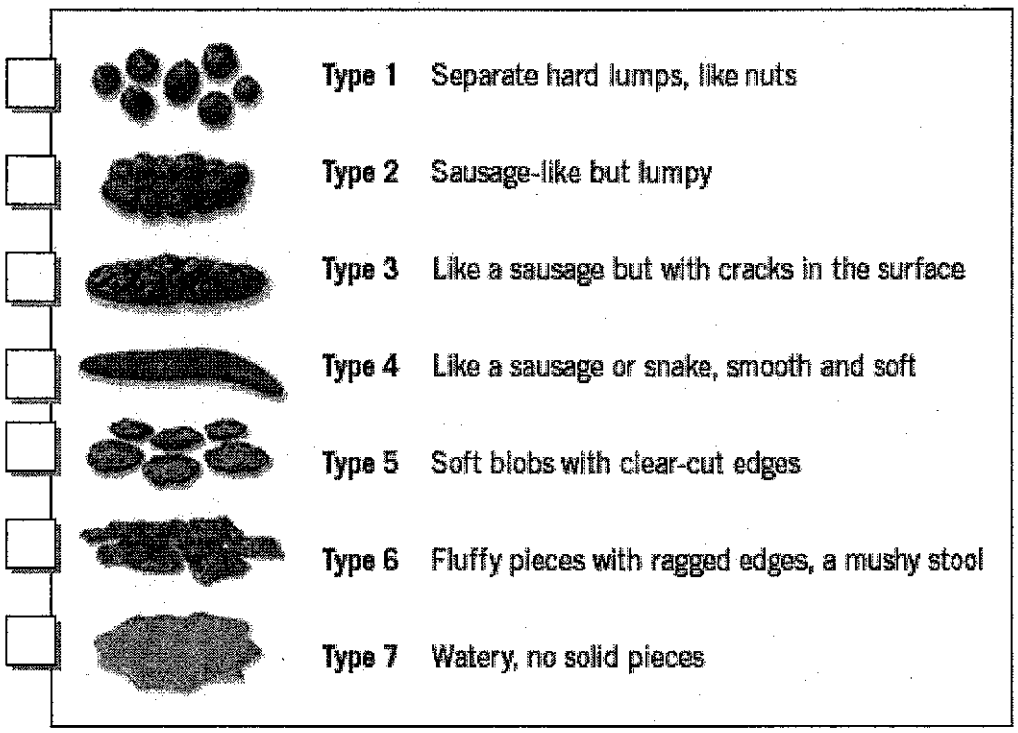
How do symptoms or conditions related to the following usually affect your ↓	**Bladder or** ***urine***	***Bowel or rectum***	***Vagina or Pelvis***
1. Ability to drive a car	☐ Not at all ☐ Somewhat ☒ Moderately ☐ Quite a bit	☐ Not at all ☒ Somewhat ☐ Moderately ☐ Quite a bit	☒ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

Please make sure to answer all 3 columns for each and every question.
Thank you for your cooperation

Name:_____ Date:_____

Bristol Stool Form Scale

Please put a check in **a single box** next to the description that best matches your current bowel habits.



When (if ever) was your last colonoscopy and what were the results?

If you checked off a box for Type 1, Type 2, or Type 3: Have you had stool like this for 3 months or greater?

- ❑ Yes
- ❑ No

Do you have any of the following?

Yes	No	
❑	❑	Unintended weight loss greater than 10 pounds
❑	❑	Onset of constipation after the age of 50 that has not been evaluated by a colon/GI doctor
❑	❑	Family history of colon cancer
❑	❑	Anemia

Revised: 01/2015

WOMEN'S PELVIC RESTORATIVE CENTER

Peter M. Lotze, M.D. • Ginger N. Cathey, M.D. • Kimberly R. Miller-Miles, M.D.
Hilaire W. Fisher, M.D. • Brandon L. Sass, M.D • Michael Anne Lane, M.D.

CLINIC FINANCIAL POLICY

We charge a $25 fee for missed clinic appointments or appointments cancelled with less than twenty-four hours' notice. We charge $50 for missed procedure (urodynamics, cystoscopy, etc) appointments or appointments cancelled with less than twenty-four hours' notice. These charges are not billable to your insurance company and you will be responsible for payment of this charge. Missed appointments often mean that someone else was not able to be seen in a more timely fashion. Please be courteous, cancel or reschedule your appointment as early as possible.

SURGERY RESCHEDULING & CANCELLATION POLICY

Please carefully consider your surgical date prior to scheduling. Your surgery requires the coordination of numerous individuals, including our staff, your surgeon, the anesthesiology department and the hospital. Rescheduling procedures requires significant time and expense, particularly if the operating room goes unused because of a late cancellation. Please be courteous and promptly make our staff aware of any decision to reschedule or cancel your surgery.

-You will be asked to pay a deposit of $100 when scheduling your surgery. This deposit is in addition to any fees you may owe for coinsurance or deductibles. Once the surgery is performed, the deposit will be returned.

-If you reschedule or cancel your surgery with less than 2 weeks' notice, the $100 fee is forfeited.

-If you reschedule or cancel your surgery for any reason with less than 72 hours' notice, there will be a mandatory fee of $200 (an additional $100).

-In order to reschedule your surgery, you must again place a $100 deposit.

Printed Name: _____ Date:_____

Signature:_____

7900 Fannin, Suite 4000 • Houston, Texas 77054 • 713-512-7000
251 Medical Center Blvd, Suite 230 • Webster, Texas 77598 • 713-578-3860

Revised: 01/2015