



THE WOMAN'S CENTER FOR ADVANCED PELVIC SURGERY

Specializing in Pelvic Floor Disorders, Urinary Incontinence & Pelvic Organ Prolapse

Dear Patient,

Thank you for contacting The Woman's Center for Advanced Pelvic Surgery. We look forward to meeting you. To help us better serve you we ask for your help with the following:

- Please contact your referring physician to request a copy of your **MEDICAL RECORDS**. The records should be faxed (480-834-5222) or mailed to our office prior to your appointment.
- Please insure that your primary care physician has processed a **REFERRAL/AUTHORIZATION** and that this information is communicated to our office prior to your appointment (*failure to do so will result in rescheduling of your appointment*). If you are self-referring, please contact our office so we can assist you in determining if you need a referral authorization.
- Please bring your **HEALTH INSURANCE CARD** to your appointment.
- **YOUR COPAYMENT /COINSURANCE IS DUE AT TIME OF SERVICE.**
We accept Visa, MasterCard, Cash or Check
- **24 HOUR NOTICE IS REQUIRED FOR RESCHEDULING OR CANCELLATIONS OF THIS AND ANY FUTURE APPOINTMENTS. FAILURE TO DO SO WILL RESULT IN A \$25 FEE BILLED TO THE PATIENT.**

Thank you for your help. We appreciate your assistance in these matters.

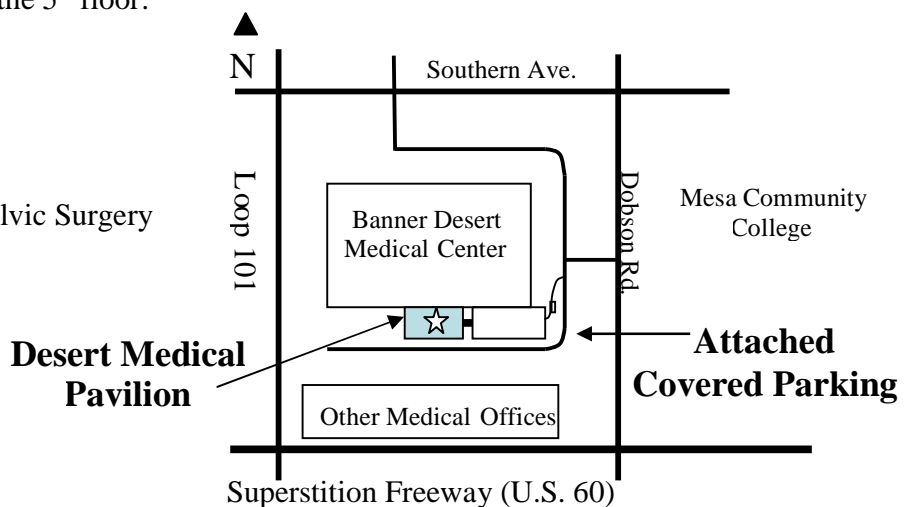
Traveling to the office should be easy. A map can be found on our website at www.twcaps.com. When you arrive, please enter the covered parking structure. Parking is FREE. Please let the attendant know you are coming to see Dr. Ryan Stratford or Dr. Ronald Burton.

We are located on the fifth floor, **suite 509**. You will find the entrance to the office down the hall on your left after you exit the elevator on the 5th floor.

We look forward to meeting you.

Respectfully,

The Woman's Center for Advanced Pelvic Surgery



1432 S. Dobson Rd. * Suite 509 * Mesa, AZ. 85202 * Phone (480) 834-5111



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PATIENT/INSURED AGREEMENT

Benefits for medical, diagnostic, and surgical services vary from plan to plan. Benefits are subject to deductibles that can range from \$200 - \$2500 or more for various types of services. We cannot bill your insurance company unless you provide us current and valid insurance information.

In an effort to provide clear communication with our patients please be aware of the following:

- The contractual agreement for your medical benefits is between you and your insurance company. *We provide billing as a courtesy.*
- For all insurance companies that we have a contract with, we will accept the "In Network" benefits as outlined on the Individual Explanation of Benefits. You the patient/insured will still be responsible for any and all co-pays, deductibles, and coinsurance amounts due in accordance with the Explanation of Benefits.
- **Our insurance contracts require us to collect deductibles and co-pays at the time of service.**
- For all insurance companies that we DO NOT have a contract with, we will accept the "Out of Network" benefits if such benefits are available. You the patient/insured are responsible for any and all co-pays, deductibles and coinsurance amounts due in accordance with the Explanation of Benefits.
- For all non-contracted insurance companies, you the patient/insured will be responsible for all charges in accordance with The Woman's Center for Advanced Pelvic Surgery's "Private Pay" fee schedule.
- When insurance benefits have been exhausted and/or terminated, you the patient will be responsible for the charges incurred in accordance with The Woman's Center for Advanced Pelvic Surgery's "Private Pay" fee schedule.
- Our staff will call to verify coverage and benefits for medical/diagnostic and surgical services provided by our office. This information is based on the information your insurance company provides and is not always a guarantee of payment.
- It is the patient/insured's responsibility to notify our office if your insurance plan or benefits change. Any costs incurred because of incorrect information provided to us by you will be your responsibility.
- **When scheduling surgery co-insurance amounts and deductibles will apply. Payment is expected prior to surgery based on the information provided to our office by your insurance company.**
- In all cases, you the patient/insured will be responsible for any non-covered services, deductibles, co-pays, and co-insurance amounts deemed as patient responsibility by your insurance company
- **Rescheduling of surgery will result in a \$100 fee.** Scheduling of surgery has a huge impact on many schedules including the surgeon, hospital operating room, surgical assistant and anesthesiologist. If you need to reschedule due to illness or unexpected circumstances, the fee may be waived.

THIS AGREEMENT SUPERSEDES ALL OTHER VERBAL AGREEMENTS

I have read and agree to be financially responsible for all services both COVERED and NON COVERED by my insurance company.

PATIENT/INSURED SIGNATURE

DATE

1432 S Dobson Rd Ste 509 * Mesa, AZ. 85202 * Phone (480) 834-5111 8 Fax (480) 834-5222

THIS OFFICE IS NOT RESPONSIBLE FOR DISPUTING INSURANCE COMPANY DECISIONS REGARDING COVERAGE



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Name: _____

Appointment Date: _____

Referring Doctor: _____

Date of Birth: _____

In order to give you the best possible care, please complete this health history questionnaire. This confidential information will give your providers the information they need to better understand your pelvic floor. If you don't understand any question, please place a "?" in the column. Your provider will review this questionnaire and ask specific questions from your answers during your appointment. Please bring this completed questionnaire to your appointment.

CC: Nature of Problem (Please summarize your bladder, bowel or pelvic floor problem(s) as briefly as possible)

Which symptom is the most bothersome? _____

Duration: How long have you had these symptoms? _____

Severity: Is your lifestyle limited because of your urinary or pelvic floor problem(s)? No Yes

If indicated, are your urinary or pelvic floor problem(s) bad enough for you to request surgery to fix them? No Yes

BLADDER FUNCTION

Frequency

How often do you typically urinate during the day? Every 15 min. 30 min. 1 hr. 2 hrs. 3hrs.

How often do you wake up to urinate during the night after going to bed? 0-1 2-3 4-5 >5

Do you ever wet the bed at night? No Yes

How often do you wet the bed? every night 2-3/wk. 1-2/wk. 1-2/mo.

Do you have a history of bedwetting or involuntary urine leakage as a child? No Yes

Urgency

When you feel the urge to urinate, do you have to rush to the bathroom? No Yes

How severe is the urge? mild moderate severe

Does the sound, sight or feel of running water cause you to lose urine? No Yes

SUI

Do you ever lose urine during any of the following activities? (check all that apply)

exercising sneezing laughing hard cough gentle cough straining walking bending

standing from a sitting position any change in position total incontinence all the time

If you leak from the above causes, is it usually: few drops wet soaked

If you leak from the above causes, how often does it occur? 1-2/mo. 1-2/wk. 1-2/day 3-5/day >5/day

For how long have you leaked from these causes? 3-6 mo. 6-12 mo. 1-2 yr. 3-5 yrs. >5 yrs.

Urge

When you feel the urge to urinate, do you ever lose urine before reaching the toilet? No Yes

If yes, when you leak is it usually: few drops wet soaked

How often do you leak from the above cause? 1-2/mo. 1-2/wk. 1-2/day 3-5/day >5/day

For how long have you leaked from these causes? 3-6 mo. 6-12 mo. 1-2 yr. 3-5 yrs. >5 yrs.

If you leak from both stress and urge-related causes, which bothers you more? stress urge

Fluids

How would you describe your daily fluid intake? 2-3 glasses 4-8 glasses > 8 glasses

Do you drink any **caffeinated** beverages? (check all that apply)

coffee number of cups/day: 0-1 2-3 4-5 >5

tea number of cups/day: 0-1 2-3 4-5 >5

soda number of cans/day: 0-1 2-3 4-5 >5

other number per day: 0-1 2-3 4-5 >5



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Pads

- Do you wear protection (pads, tissues etc.) for urine loss? No Yes
 What type of protection do you use? tissue mini-pad regular heavy (diaper)
 How many pads do you wear in the daytime? 0-1 2-3 4-5 >5
 How many pads do you wear at night? 0-1 2-3 4-5 >5
 How wet are your pads when you change them? few drops wet soaked

Modifying Factors

- Have you ever tried Kegel or pelvic floor exercises to help your problem? No Yes
 If so, did they help? No Yes
 Have you ever been given medication to help with your leakage problem? No Yes
 If so, did it help? No Yes
 What medication(s) have you used? _____

Associated Signs & Symptoms

- Do you have pain or burning when you urinate? No Yes
 Do you have pain when your bladder is full? No Yes
 If so, does the pain resolve when you empty? No Yes
 Can you feel when your bladder is full? No Yes
 Can you feel when you have leaked urine? No Yes
 Have you ever had blood in your urine not associated with a bladder infection? No Yes

Obstructive Symptoms

Check all that apply

	Never	Sometimes	Often	Always	Don't know
Delay in starting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Straining to urinate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slow urine flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine flow that stops and starts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incomplete emptying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dribbling after void	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't empty at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

BOWEL FUNCTION

- How many bowel movements do you have? 1-2/day every other day 1-2/wk. 1-2/mo.
 How often do you have to strain hard to have a bowel movement? <25% 25-50% 50-75% >75%
 Do you require laxatives to have a bowel movement? No Yes

Anal Incontinence

- Do you ever leak stool or gas accidentally? No Yes
 How often do you leak gas? 1-2/day 1-2/wk. 1-2/mo. 1-2/yr. 1-2 times in my lifetime
 How often do you leak liquid stool? 1-2/day 1-2/wk. 1-2/mo. 1-2/yr. 1-2 times in my lifetime
 How often do you leak solid stool? 1-2/day 1-2/wk. 1-2/mo. 1-2/yr. 1-2 times in my lifetime
 When was the last time you accidentally leaked solid stool? few weeks ago few months ago year ago

PROLAPSE

- Do you ever feel a bulge or feel that something is "falling out" of the vagina? No Yes
 If so, when was the first time you noticed it? _____ (month / year)
 Have you ever used a vaginal support device (pessary)? No Yes

Splinting

- Do you have to use your fingers to apply pressure on the vagina or rectum to have a bowel movement? N Y
 If yes, where? In the vagina On the outside between the vagina and rectum
 Do you have to manually remove stool with a finger in the rectum to have a bowel movement? No Yes
 Do you ever have to push tissue back into the vagina to urinate or defecate? No Yes



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SEXUAL FUNCTION

Pelvic floor problems often interfere with sexual relations. In order to best treat you, it is important to obtain this information. If you feel uncomfortable answering these questions prior to your appointment, please discuss these issues with your provider at the time of your initial visit.

Are you sexually active at this time in your life? No Yes

Do those sexual activities include vaginal intercourse? No Yes

Is your sex life satisfactory for you? No Yes

Do you have any sexual concerns that you would like to address? No Yes

Dyspareunia

Do you have pain with intercourse? No Yes

If so, where is the pain? superficial deep both

Do you have vaginal dryness? No Yes

Associated Signs & Symptoms

Are your sexual activities limited due to vaginal relaxation (prolapse)? No Yes

Do you ever leak urine with vaginal intercourse? No Yes

If so, when does it occur? with penetration with orgasm both

MEDICAL HISTORY

Please note if you have had any of the following medical conditions:

Neurological disease No Yes

Diabetes No Yes

Asthma / Lung disease No Yes

Heart disease No Yes

High blood pressure No Yes

Blood transfusion No Yes

Psychiatric disease No Yes

Other medical history: _____

Urinary infections No Yes # in last yr _____

Thyroid disease No Yes

Kidney infections No Yes

Kidney stones No Yes

Liver disease No Yes

History of cancer No Yes

Pelvic radiation No Yes

MEDICATIONS (Please list all medications, including dosage, that you are taking)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES

Do you have any drug allergies? No Yes

If yes, please list them: _____

SURGICAL HISTORY

1. Have you had a hysterectomy? No Yes If yes, what type?

Vaginal Abdominal

2. Have you had your ovaries removed? No Yes

3. Please list all other surgeries you have had – the type and year of each surgery.

1. _____

5. _____

2. _____

6. _____

3. _____

7. _____

4. _____

8. _____



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GYNECOLOGIC HISTORY

When was your last menstrual period? _____ (month / day / year)

Have you had any abnormal uterine bleeding? No Yes

If you **have not** reached menopause: What do you use for birth control? _____

If you **have** reached menopause: Have you ever been on hormone replacement therapy? No Yes

If yes, what medication did you use? _____ For how long? _____ Years Months

Have you ever had an **abnormal** pap smear? No Yes

If so, when was it abnormal? _____ (month / year)

When was your last pap smear? _____ (month / year)

Pregnancy

(Please include all pregnancies)

	1	2	3	4	5	6	7	8
Year of birth								
Gestational age at delivery (weeks)								
Type of delivery (vaginal, c-section)								
Birth weight								
Were forceps or vacuum used?								
Episiotomy performed?								
Were lacerations sutured in vagina?								
Duration of labor (hrs.)								
Duration of pushing (hrs.)								

FAMILY HISTORY

Mother: Living Deceased – Cause _____ Age _____

Father: Living Deceased – Cause _____ Age _____

Siblings: Number living _____ Number Deceased _____ Cause(s) _____

Has anyone in your family had any of the following diseases? (Check all that apply)

Kidney disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Breast cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Ovarian cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Colon cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hypertension	<input type="checkbox"/> No <input type="checkbox"/> Yes	Other cancer	_____

SOCIAL HISTORY

Do you have a regular exercise program? No Yes, please describe _____

Have you worked outside the home? No Yes, please describe _____

What is your marital status? Single Married Divorced Widowed Other

How many people live in your household? _____

Smoking: Never smoked Smoked in the past Currently smoke -- For how many years? _____

How many **packs** of cigarettes do/did you smoke in a day? _____

Alcohol: No Yes How many drinks do you consume on average? 1-2/mo. 1-2/wk. 1-2/day >2/day

Review of Systems (Please circle any of the following problems that you have experienced over the last year)

Constitutional	Unusual fatigue	Weight loss	Loss of appetite
Eyes:	Double vision	Blurred vision	Glasses / Contacts
ENT:	Deafness	Hoarseness	ringing in ears
Cardiac:	Chest pain	Irregular beats	Palpitations
Pulmonary:	Shortness of breath	Chronic cough	Wheezing
Musculoskeletal:	Muscle weakness	Lower back pain	Hip pain
Skin:	Bruising	Hair loss	Unexplained rash
Neurologic:	Seizures	Frequent headaches	Numbness
Psychiatric:	Depressed	Difficulty sleeping	Memory loss
Endocrine:	Hot flashes	Dry skin	Sensitive to heat / cold
Blood disease:	Anemia	Bleeding problems	Enlarged lymph gland
Allergy:	Sinus problems	Allergic reaction	Conjunctivitis