San Buenaventura Urogynecology

Community Memorial Health System
Jill C. Hall, M.D. & Michelle Takase-Sanchez, M.D.
Female Pelvic Floor Medicine & Reconstructive Surgery
2705 Loma Vista Road, Suite #206, Ventura, CA 93003
(805)948-6041: Fax (805)948-6841

Name:_____ **DOB:**_____ **Age:**____ **Date:**_____

Referring Physician: _____ **Primary Care Physician:** _____

GYNECOLOGIC HISTORY

Last Normal Menstrual Period:_____ Age At First Menstrual Period:_____ _

Length of Periods: _____ Number of Days Between Periods:_____Do you have clots?: YES NO

Do you have painful periods?: YES NO Do you bleed between cycles?: YES NO

Do you have painful intercourse?: YES NO Last Pap Test:_____ Any Abnormal Results?: YES NO

If So When?:______ Last Mammogram:______ Any Abnormal Results?: YES NO

If So When?: _____ Last Colonoscopy:_____ Last Bone Density: _____

Method of Contraception: ____ Sterilization (partner/self) _____ Depo Provera _____ IUD _____ Pills

_____Diaphragm _____ Natural Family Planning _____ Foam/Gel _____Other: _____

Do you leak urine?: YES NO _____All the time _____With Lifting/Coughing _____Occasionally

Do you wear incontinence pads? YES NO If so, how many per day? _____ Do you leak stool? YES NO

OB HISTORY

Pregnancies # _____ Births # _____ Miscarriages # _____ Cesareans # _____ Abortions # _____ None _____

MEDICAL HISTORY

___ Asthma	____ Mitral Valve Prolapse	____ Breast Cancer	____ Fibroids
___ Anemia	____ Arthritis	____ Endometriosis	____ Condyloma/Warts
___ Diabetes	____ Hepatitis	____ Fibrocystic Breasts	____ Ovarian Cysts
___ High Blood Pressure	____ Deep Vein Thrombosis	____ Thyroid Disease	____ Gonorrhea/Chlamydia
___ High Cholesterol	____ Fibromyalgia	____ Bleeding Disorder	____ Genital Herpes
___ Heart Attack	____ Frequent Bladder Infection	____ Ulcerative Colitis	____ Ulcer/GERD
___ Stroke	____ Depression/Anxiety	____ Blood Transfusion	____ HIV/AIDs

___ Other: _____

SURGICAL HISTORY

Type of Surgery	Reason for Surgery	Date of Surgery

ALLERGIES: _____

MEDICATIONS (Name, Dosage& Frequency; *Including Supplements & Herbs)*

Name: _____ **DOB:** _____ **Age:** _____ **Date:** _____

SOCIAL HISTORY

Occupation: _____ How many hours do you work/week? _____

Have you ever been sexually active? YES NO Are you currently sexually active? YES NO

Have you ever been raped or abused? YES NO Are you currently safe in your relationship? YES NO

Do you smoke? YES NO FORMER If yes, how many packs per day? _____ How many years? _____

Are you interested in smoking cessation? YES NO Maybe next year? YES NO

How much alcohol do you drink? _____

How much coffee/tea do you drink? _____

Any recreational drugs? YES NO If yes, what kind? _____

How much do you exercise? _____

FAMILY HISTORY (indicate age and health issues for each)

Mother: _____ Father: _____

Sisters: _____ Brothers: _____

___ Breast Cancer	____ Ovarian Cancer	____ Uterine Cancer	____ Cervical Cancer
___ Bladder Cancer	____ Colon Cancer	____ Diabetes	____ Heart Disease
___ High Cholesterol	____ Hypertension	____ Osteoporosis	____ Renal Cancer

REVIEW OF SYSTEMS (mark any persistent symptoms you currently have)

ENDOCRINE

___ Thyroid Disease (Goiter, Nodules, Mashimoto, Graves' Disease, Hypothyroidism, Thyroid Cancer, Thyroid Surgery)
___ Parathyroid (Hyperparathyroidism, Hypoparathyroidism, Parathyroid Cancer, Parathyroid Surgery) _____
___ Pituitary Disease ____ Adrenal Disorder
___ Diabetes (Year Diagnosed? ____ Complications: _____

NEPHROLOGICAL

___ Renal Disease
___ Angina
___ Nephritis
___ Phlebitis
___ Circulatory Problems
___ Rheumatic Fever

MUSCULOSKELETAL

____ Joint Pain
____ Gout
____ Fractures
____ Arthritis

HEMATOLOGICAL

____ Hepatitis/Jaundice
____ Bleeding Tendency
____ Swollen Glands
____ Anemia
____ HIV/AIDS

GASTROINTESTINAL

_____ Hiatal Hernia
_____ Ulcers
_____ Colitis
_____ Blood in Stool
_____ Colon Cancer
_____ Nausea/Vomiting

SKIN

___ Shingles
___ Rashes/Hives

RESPIRATORY

____ Bronchitis
____ Emphysema
____ Shortness of Breath

NEUROLOGICAL

____ Seizures
____ Stroke
____ Parkinson's Disease

CONSTITUTIONAL

_____ Chills
_____ Weight Loss
_____ Cancer
_____ Appetite Change
_____ Depression

GYNECOLOGIC

___ Ovarian Cyst/Cancer
___ PCOS
___ Breast Cancer
___ Heavy Menses
___ Irregular Periods
___ Menopause
___ Hormone Replacement
___ Uterine or Cervical Cancer

UROLOGICAL

____ Cancer_____
____ Stones
____ Pain/urgency/frequency
____ Blood in urine
____ Burning with Urination
____ Trouble Emptying Bladder

CARDIOVASCULAR

____ Arrhythmia
____ Heart Attack
____ Valve Disease
____ Peripheral Vascular Disease (angioplasty, stents, Femoral-popliteal bypass, amputations)
_____ Heart Murmur
_____ Stroke
_____ High Blood Pressure

OTHER

_____

_____

_____

_____

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Pelvic Floor Distress Inventory

INSTRUCTIONS

This questionnaire is necessary for your doctor to know how best to address each of your problems. You will be evaluated by a specialist in Urogynecology who focuses on pelvic floor disorders that involve bowel, bladder and pelvic conditions.

Please answer ALL of the questions in the following survey (front/ back). These are symptoms that have been recently bothering you within the last year that brings you to see the Urogynecologist. This should take you 5 minutes to complete.

There are two parts to each question.

1. First check the box YES or NO if you have the symptom.

2. Then, if you answer YES, please select one of your boxes indicating how much bother the symptom is causing you.

There is no right or wrong answer. Please just pick the very best, single answer.

Please disregard the scoring sections. This is for your provider to fill out if necessary.

Thank you for taking the time to fill out this questionnaire.

Center for Female Continence PFDI-20

PT Initials_____ DOB _____ DATE _____ I.D. Number _____ Research Site _____

Pre ☐ 3 mo ☐ 6 mo ☐ 12 mo ☐ 24 mo ☐ 36 mo ☐ 60 mo

POPDI-6

1. **Usually experience ***pressure*** in the lower abdomen?**
   ☐ No ☐ Yes If yes, how much does it bother you?

   Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit ☐ Score

2. **Usually experience ***heaviness or dullness*** in the pelvic area?**
   ☐ No ☐ Yes If yes, how much does it bother you?

   Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit ☐ Score

3. **Usually have a bulge or something falling out that you can see or feel in your vaginal area?**
   ☐ No ☐ Yes If yes, how much does it bother you?

   Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit ☐ Score

4. **Ever have to push on the vagina or around the rectum to have or complete a bowel movement?**
   ☐ No ☐ Yes If yes, how much does it bother you?

   Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit ☐ Score

5. **Usually experience a feeling of incomplete bladder emptying?**
   ☐ No ☐ Yes If yes, how much does it bother you?

   Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit ☐ Score

6. **Ever have to push up on a bulge in the vaginal area with your fingers to start of complete urination?**
   ☐ No ☐ Yes If yes, how much does it bother you?

   Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit ☐ Score

POPDI-6 Total x 25 =

PT Initials_____ DOB _____ DATE _____ I.D. Number _____ Research Site _____

CRADI-8

7. Feel you need to strain too hard to have a bowel movement?

☐ No ☐ Yes If yes, how much does it bother you?

Not at all	Somewhat	Moderately	Quite a bit	Score
☐	☐	☐	☐	

8. Feel you have not completely emptied your bowels at the end of a bowel movment?

☐ No ☐ Yes If yes, how much does it bother you?

Not at all	Somewhat	Moderately	Quite a bit	Score
☐	☐	☐	☐	

9. Usually have stool escape beyond your control if your stool is well formed?

☐ No ☐ Yes If yes, how much does it bother you?

Not at all	Somewhat	Moderately	Quite a bit	Score
☐	☐	☐	☐	

10. Usually have stool escape beyond your control if your stool is loose?

☐ No ☐ Yes If yes, how much does it bother you?

Not at all	Somewhat	Moderately	Quite a bit	Score
☐	☐	☐	☐	

11. Usually lose gas from the rectum beyond your control?

☐ No ☐ Yes If yes, how much does it bother you?

Not at all	Somewhat	Moderately	Quite a bit	Score
☐	☐	☐	☐	

12. Usually have pain when you pass your stool?

☐ No ☐ Yes If yes, how much does it bother you?

Not at all	Somewhat	Moderately	Quite a bit	Score
☐	☐	☐	☐	

13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?

☐ No ☐ Yes If yes, how much does it bother you?

Not at all	Somewhat	Moderately	Quite a bit	Score
☐	☐	☐	☐	

14. Does part of your bowel ever bulge outside the rectum during or after a bowel movement?

☐ No ☐ Yes If yes, how much does it bother you?

Not at all	Somewhat	Moderately	Quite a bit	Score
☐	☐	☐	☐	

CRADI-8 Total x 25 =

PT Initials_____ DOB _____ DATE _____ I.D. Number _____ Research Site _____

UDI-6

15. Usually experience frequent urination?

☐ No ☐ Yes If yes, how much does it bother you?

Not at all	Somewhat	Moderately	Quite a bit	Score
☐	☐	☐	☐	

16. Usually experience urine leakage associated with a feeling of urgency, i.e. a strong sensation of needing to go to the bathroom?

☐ No ☐ Yes If yes, how much does it bother you?

Not at all	Somewhat	Moderately	Quite a bit	Score
☐	☐	☐	☐	

17. Usually experience urine leakage with coughing, laughing or sneezing?

☐ No ☐ Yes If yes, how much does it bother you?

Not at all	Somewhat	Moderately	Quite a bit	Score
☐	☐	☐	☐	

18. Usually experience small amounts of urine leakage (small drops of urine)?

☐ No ☐ Yes If yes, how much does it bother you?

Not at all	Somewhat	Moderately	Quite a bit	Score
☐	☐	☐	☐	

19. Usually experience difficulty emptying your bladder?

☐ No ☐ Yes If yes, how much does it bother you?

Not at all	Somewhat	Moderately	Quite a bit	Score
☐	☐	☐	☐	

20. Usually experience *pain or discomfort* in the lower abdomen or genital region?

☐ No ☐ Yes If yes, how much does it bother you?

Not at all	Somewhat	Moderately	Quite a bit	Score
☐	☐	☐	☐	

UDI-6 Total x 25 =

Scale scores: Obtain the mean value of all the answered items within the corresponding scale (possible value 0-4) and then multiply by 25 to obtain the scale score (range 0-100). Missing items are dealt with by using the mean from answered items only.

PFDI-20 Summary Score: Add the scores from the 3 scales together to obtain the summary score (range 0-100)

POPDI-6 _____
CRADI-8 _____
UDI-6 _____

PFDI-20 Score _____

Center for Female Continence PFIQ-7

PT Initials_____ DOB _____ DATE _____ I.D. Number _____ Research Site _____

Pre ☐ 3 mo ☐ 6 mo ☐ 12 mo ☐ 24 mo ☐ 36 mo ☐ 60 mo

Pelvic Floor Impact Questionnaire – short form 7

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 much your activities, relationships, and feelings have been affected by your bladder, bowel or vaginal symptoms or conditions **over the last 3 months.** Please make sure you mark an answer in **all 3 columns** for each question.

How do symptoms or conditions in the following usually affect your	**Bladder or Urine**	**Bowel or Rectum**	**Vagina or Pelvis**
1. Ability to do household cores (cooking, laundry, housecleaning)?	☐ 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. Ability to do physical activities 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 such as going to a movie or concert?	☐ 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 for a distance greater than 30 minutes away 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. Participating 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
Total	x 100	x 100	x 100

Scoring the PFIQ-7:

All of the items use the following response scale:
0, Not at all; 1, Somewhat; 2, Moderately; 3, Quite a Bit **PFIQ-7 Score _____**

Scales:

Urinary Impact Questionnaire (UIQ-7): 7 Items under column heading “Bladder or urine”
Colorectal-Anal Impact questionnaire (CRAIQ-7): 7 items under column heading “Bowel or Rectum”
Pelvic Organ Prolapse Impact Questionnaire (POPIQ-7): 7 items under column heading “Pelvis or Vagina”
Scale Scores: Obtain the mean value for all of the answered items within te corresponding scale (possible value 0-3) and then multiply by (100/3) to obtain the scale score (range 0-100).
Missing items are dealt with by using the mean from answered items only.
PFIQ Summary Score: Add the scores from the 3 scales together to obtain the summary score (range 0-300).

Community Memorial Health System

Where Excellence Begins with Caring

E-PRESCRIBING CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send an accurate , error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** - Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that CMH Centers for Family Health can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Name	Patient DOB
Signature of Patient or Guardian	Date
Relationship to Patient	Pharmacy Name

Centers for Family Health
Community Memorial Health System

Acknowledgement of Notice of Privacy Practices

Legal Advice Disclaimer.
This document and the information on it do not constitute legal advice. It is also not a substitute for legal or other professional advice. Users should consult their own legal counsel for advice regarding the application of the law and this document as it applies to HIPAA regulations.

Patient Name _____

I hereby acknowledge that I have received the Notice of Privacy Practices statement of Community Memorial Health System.

Signature_____Date _____

Reconocimiento Del Aviso De las Practicas De Privacidad

Este documento y la información en el no constituye acesoramiento jurdico. Asi Como no es un substituto para consejo legal u otro consejo proffesional. Los usuarios debén consultar sus propios consejeros legales para consejo con respecto al uso de la ley y de este documento como aplica a las regulaciones de HIPAA.

Nombre del Paciente _____

Yo reconozco por este medio que he recibido el aviso de la Declaracion de las Practicas de Privacidad de Community Memorial Health System.

Firma_____ Fecha _____

TO BE COMPLETED BY STAFF:

Complete if signature requested but not obtained:

Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

☐ Patient/personal representative refused to sign form.

☐ Other: _____

PATIENT IDENTIFICATION

San Buenaventura Urology Center

Community Memorial Health System

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with federal government privacy rule Implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for Physician or staff of Community Memorial Healthcare Systems (CMHS), Centers for Family Health (CFH) to release your medical information, we must obtain your authorization prior to doing so. However, in the event\ of critical episode, or if you are unable to give your authorization due to the severity of your condition, the law stipulates that these rules may be waived. Please indicate your preferences below.

Patient Name:_____

Mailing Address:_____

_____

Contact Phone #:_____

_____ I authorize CMHS CFH to send letters containing any or all of my medical information, including test results and recommendations to the address provided above.

_____ I authorize CMHS CFH to leave messages on the answering machine at the phone number provided above.

_____ I authorize CMHS CFH to verbally release any or all information concerning my medical care to the following individual(s).

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I understand that it is my responsibility to inform CMHS CFH promptly in writing of any changes I wish to make to this authorization. This authorization to remain effective until _____ (not to exceed 24 months).

Patient Signature: _____ Date: _____

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