ADVANCED **GYNECOLOGY**

FEMALE
New Patient Registration

DEMOGRAPHICS

Patient Information: Need help with forms? ☐ Y ☐ N

Gender: ☐ Male ☐ Female ☐ Other:_____ Preferred pronouns: ☐ She/Her ☐ He/Him ☐ They/Them

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Social Security: _____-_____-_____ Marital Status: _____ Race:_____

Phone:_____ Email:_____

May we leave a detailed voice message? ☐ Y ☐ N May we send a detailed text message? ☐ Y ☐ N

Primary Care Physician: (Name) _____ (Phone) _____

Referring Physician: (Name) _____ (Phone) _____

Preferred Pharmacy: (Name) _____ (Phone) _____

Do you have a cardiologist? ☐ Y ☐ N Cardiologist Name: _____ (Phone) _____

Emergency Contact: (Name) _____ (Phone) _____(Relationship)_____

Do you live in an assistant living facility? ☐ Y ☐ N Name of facility: _____

(City) _____ (State) _____ Do you have an Advance Directive (Living Will)? ☐ Y ☐ N

EMPLOYMENT

Employer: _____ Occupation _____

Phone _____ (Address) _____

(City) _____ (State) _____ (Zip) _____

NOTICE OF PRIVACY PRACTICE

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I have been provided a copy of Advanced Gynecology's Privacy Practices as required by the Health Insurance Portability Act (HIPAA) to ensure that I have been made aware of my privacy rights. _____ **Initial Here**

Patient Name:_____ DOB:_____ Phone:_____

I authorize Advanced Gynecology to release my health information to persons/organizations listed below:

Name:_____ Name:_____

Relationship:_____ Phone:_____ Relationship:_____ Phone:_____

By signing this document, I acknowledge the following:

- I have reviewed this authorization to release my medical records and confirm it is correct.
- I understand that this authorization will remain in effect for a period of one (1) year, unless revoked.
- I may revoke this authorization at any time by writing to: Advanced Gynecology, ATTN: Medical Records
- 1561 Janmar Rd., Snellville, GA 30078: The revocation will become effective upon receipt of the notice.

_____ _____

Signature of patient (or guardian) Date

ADVANCED **GYNECOLOGY**

Patient Acknowledgement & Consents

PAYMENT POLICY

Please *initial and sign* to your acknowledgement and consent for Medical Treatment, Notice of Privacy Practices, Authorization to release medical information and Payment Policy.

Thank you for choosing Advanced Gynecology as your provider. We are committed to providing you with quality and affordable health care. Please be sure to carefully read our payment policy. A copy will be provided upon request.

- ***Insurance.*** We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- ***Co-payments and deductibles***. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. If your account is turned over to a collection agency, a $100 collections processing fee will be added to any outstanding balance.
- ***Non-covered services***. Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
- ***Proof of insurance***. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- ***Claims submission***. We will submit your claims and assist you in any way we can to help get your claims paid. Please be aware that any unpaid balances are your responsibility.
- ***Coverage changes***. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
- ***Nonpayment.*** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

_____ **INITIAL HERE**

CONSENT TO MEDICAL TREATMENT

I have reviewed and consent to the following:

- I voluntarily present for treatment and consent to my provider to provide my care. Such care may include, but is not limited to, diagnostic procedures, blood draws, laboratory tests, medication administration, and other procedures considered advisable in my diagnosis, treatment and course of care.

- I acknowledge that my treatment is intended to address specific illnesses and is not intended as a substitute for a primary care physician and that no guarantee can be made or has been made as to the results of treatments or examinations at Advanced Gynecology.

- In the event an employee has a needle stick or otherwise is exposed to my blood or body fluids, I consent to testing for HIV or Hepatitis C & B.

_____ **INITIAL HERE**

SIGNATURES

By signing below, I acknowledge that I have reviewed Advanced Gynecology's payment policy and consent to medical treatment.

Print name of person signing: _____ Relationship to patient: _____

_____ _____

Signature of patient (or guardian) Date

ADVANCED GYNECOLOGY

Request for Healthcare information
Please forward the healthcare records of the following patient
Fax to 678.666.5201 or mail to 1561 Janmar Rd., Snellville, GA 30078

Authorization to obtain protected healthcare information

Patient Name (LAST) _____ (FIRST) _____ (MI) _____ (Suffix) _____

Date of Birth: _____/_____/_____ Phone: _____

☐ I authorize Advanced Gynecology to obtain and the named facilities to release to Advanced Gynecology my healthcare information.

This release applies to:

☐ All my healthcare information

☐ Healthcare information related to the following treatment, condition or dates

_____

☐ Other

_____

_____

For Office Use Only

Facility: (Name) _____

Address:

_____

Phone: _____

(Fax)_____

_____ _____/_____/_____

Signature of patient (or guardian) Date

_____ _____

Print name of person signing Relationship to patient

ADVANCED **GYNECOLOGY**

Patient History

Patient Name: _____ Date of birth: _____

Height: _____ Weight: _____

Please tell us the reason for your visit today:_____

SYSTEM REVIEW

Have you experienced any of the following?

Constitutional			**Cardiovascular**			**Endocrine**		
Change in appetite	☐ Y	☐ N	Change in appetite	☐ Y	☐ N	Cold intolerance	☐ Y	☐ N
Chills	☐ Y	☐ N	Chills	☐ Y	☐ N	Heat intolerance	☐ Y	☐ N
Fatigue	☐ Y	☐ N	Fatigue	☐ Y	☐ N	Excessive thirst	☐ Y	☐ N
Fever	☐ Y	☐ N	Fever	☐ Y	☐ N	Excessive urination	☐ Y	☐ N
Eyes			**Respiratory**			Weight gain	☐ Y	☐ N
Dry eyes	☐ Y	☐ N	Cough	☐ Y	☐ N	Weight loss	☐ Y	☐ N
Blurred vision	☐ Y	☐ N	Wheezing	☐ Y	☐ N	Excessive sweating	☐ Y	☐ N
Changes in vision	☐ Y	☐ N	Shortness of breath	☐ Y	☐ N	Night sweats	☐ Y	☐ N
ENT			Painful respiration	☐ Y	☐ N	Dry skin	☐ Y	☐ N
Dry mouth	☐ Y	☐ N	Sleep apnea	☐ Y	☐ N	**Gastrointestinal**		
Headaches	☐ Y	☐ N	**Allergic-Immunologic**			Abdominal pain	☐ Y	☐ N
Nasal congestion	☐ Y	☐ N	Rash	☐ Y	☐ N	Constipation	☐ Y	☐ N
Runny nose	☐ Y	☐ N	Allergic dermatitis	☐ Y	☐ N	Diarrhea	☐ Y	☐ N
Sinus pain	☐ Y	☐ N	Itching	☐ Y	☐ N	Bloody stool	☐ Y	☐ N
Sore throat	☐ Y	☐ N	Frequent illness	☐ Y	☐ N	Loss of appetite	☐ Y	☐ N
Breast			Sinus allergies	☐ Y	☐ N	Nausea/vomiting	☐ Y	☐ N
Lumps	☐ Y	☐ N	**Musculoskeletal**			Heartburn	☐ Y	☐ N
Nipple discharge	☐ Y	☐ N	Back pain	☐ Y	☐ N	**Genito - Urinary**		
Swelling	☐ Y	☐ N	Bone/Joint pain	☐ Y	☐ N	Decreased sex drive	☐ Y	☐ N
Tenderness	☐ Y	☐ N	Muscle pain	☐ Y	☐ N	Decreased stream	☐ Y	☐ N
Neurological			Muscle weakness	☐ Y	☐ N	Difficulty voiding	☐ Y	☐ N
Headaches	☐ Y	☐ N	**Hematology/Lymphatic**			Dysuria (painful urination)	☐ Y	☐ N
Poor coordination	☐ Y	☐ N	Easy bleeding	☐ Y	☐ N	Impotence	☐ Y	☐ N
Numbness or tingling	☐ Y	☐ N	Easy bruising	☐ Y	☐ N	Scrotal pain	☐ Y	☐ N
Seizures	☐ Y	☐ N	History of DVT	☐ Y	☐ N	Vaginal discharge	☐ Y	☐ N
Dizziness	☐ Y	☐ N	Lymph node enlargement	☐ Y	☐ N	Dysmenorrhea (painful periods)	☐ Y	☐ N
Confusion	☐ Y	☐ N						

SOCIAL HISTORY

Tobacco Use

- Do you use tobacco products? ☐ Yes ☐ No (How long?) _____ (How much?) Packs/day:_____
- Are you a former smoker? ☐ Yes ☐ No (Quit date?) _____

Alcohol Use

- Do you consume alcohol? ☐ Yes ☐ No (Type?) ☐ Beer ☐ Wine ☐ Liquor

How much? _____ drinks per ☐ Day ☐ Week ☐ Month (Date of last drink?)_____/_____/_____

Drug Use Do you routinely use any illegal substances? ☐ Yes ☐ No

Caffeine Use ☐ I do not drink caffeinated beverages

☐ Current caffeine (How much?) _____ drinks/day (How long?) _____ years

Exercise ☐ I do not exercise ☐ Exercise regularly _____minutes/day for _____ days/week

Seatbelt Do you routinely wear seatbelts? ☐ Yes ☐ No

ADVANCED **GYNECOLOGY**

Patient History

ALLERGIES

Do you have any known allergies? ☐ Yes ☐ No ☐ Latex ☐ Band-aids/Adhesives ☐ Iodine

- List all medication allergies

Name of medication	Reaction to medication

- List all other allergies:

CURRENT

- List ALL current medications including over the counter, birth control, vitamins, herbals & prescriptions

Medication Name & Dose	Medication Name & Dose

PAST MEDICAL

• List ***ALL*** current or past medical conditions	• List ***ALL*** surgeries including the year

OBGYN HISTORY

- Are you currently pregnant? ☐ Yes ☐ No ☐ Don't know
- Number of pregnancies: _____
- Number of Vaginal deliveries: _____
- Cesarean deliveries: _____
- Largest infant weight: _____
- Date of last period:_____
- Age at first period:_____
- Average length of period:____ days
- Pads/day:___
- Date of last pap smear: _____
- Previous abnormal paps? ☐ Yes ☐ No
- Last mammogram:
- Date: [Month]_____ [Year]_____
- Result: ☐ Normal ☐ Abnormal
  - Location mammogram was done: _____
- Are you currently taking any hormone replacement therapy? ☐ Yes ☐ No
  - If yes, list name and route:_____

FAMILY HISTORY

- Do any family members have history of the following?

☐ Bleeding disorder Relationship:	☐ Clotting disorder Relationship:	☐ Diabetes Relationship:	☐ Coronary artery/Heart disease Relationship:
☐ High cholesterol Relationship:	☐ High blood pressure Relationship:	☐ Stroke Relationship:	☐ Early menopause Relationship:
☐ Reaction to anesthesia Relationship:	☐ Thyroid disease Relationship:	☐ Infertility Relationship:	☐ Inflammatory bowel disease Relationship:
☐ Prolapse Relationship:	☐ Breast cancer Relationship:	☐ Gyn cancer (ovarian, uterine, cervical) Relationship:	
☐ Colon Cancer Relationship:	☐ Other Cancer (Type)_____ Relationship:_____ (Type)_____ Relationship:_____		
☐ Other:			

ADVANCED **GYNECOLOGY**

Gynecologic Survey

Name:	DOB:	Today's date:

The following questions ask about your vagina and other reproductive organs.
Please review and answer all questions as best as you can.

Do you usually experience any of the following? (**Check all that apply**)

☐ Pressure in the lower abdomen	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
☐ Heaviness or dullness in the pelvic area	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
☐ A bulge or something falling out that you can see or feel in your vaginal area	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
☐ Having to push on the vagina or around the rectum to have or complete a bowel movement	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
☐ Feeling of incomplete bladder emptying	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
☐ Having to push up on a bulge in the vaginal area with your fingers to start or complete urination	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

- Have you ever had any of the following treatments for prolapse?

  ☐ Surgery[Type_____] ☐ Pessary ☐ Pelvic floor physical therapy

- Have you had a hysterectomy? ☐ Yes ☐ No
  - Were the ovaries and tubes removed? ☐ Yes ☐ No ☐ Don't Know
  - Was the cervix removed? ☐ Yes ☐ No ☐ Don't Know
  - What was the route of the hysterectomy? ☐ Vaginal ☐ Laparoscopic/Robotic

    ☐ Vaginal ☐ Laparoscopic/Robotic ☐ Open/Abdominal
- Have you had any other surgeries to the reproductive organs, bladder, urethra, or rectum/anus?

- Do you have any vaginal dryness? ☐ Yes ☐ No
- Do you have any vaginal discharge? ☐ Yes ☐ No
- Do you have any vaginal or vulvar itching or irritation? ☐ Yes ☐ No
- Are you sexually active?
  - With (Check all that apply) ☐ Men ☐ Women ☐ Both
  - Do you have any pain with sex? ☐ Yes ☐ No
  - Do any of the following restrict you from having a healthy sex life **(Check all that apply)**

    ☐ Urine leakage ☐ Bowel leakage ☐ Vaginal dryness ☐ Vaginal laxity

    ☐ Vaginal bulge ☐ Lack of interest ☐ Difficulty achieving orgasm
- Do you currently have any pelvic pain? ☐ Yes ☐ No
  - If yes, please answer the following questions:
    - Location: _____
    - How long have you had this? _____ • Severity (**Check one**): ☐ Minimal ☐ Moderate ☐ Severe
    - Pain Scale **(Circle one) [0 = No pain, 10 = Worst pain imaginable]** 1 2 3 4 5 6 7 8 9 10
    - Quality **(Check One)** ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Crampy ☐ Dull ☐ Achy
    - Radiation? (Spreads elsewhere): ☐ Yes ☐ No Where: _____
    - Exacerbating factors (makes it worse):_____
    - Alleviating factors (make it better):_____
- Have you tried any of the following treatments for your pelvic pain? (**Check all that apply**)

  ☐ Elavil/Amitriptyline ☐ Uribel ☐ Prelief ☐ Neurontin/Gabapentin ☐ NSAIDS

  ☐ Valium suppositories ☐ Uristat/Azo ☐ Pyridium ☐ Muscle relaxants ☐ Narcotics

  ☐ Pudendal nerve block ☐ Bladder instillations ☐ Hydrodistension ☐ Cystoscopy

  ☐ Elmiron/PPS ☐ Estrogen cream/tabs ☐ Laser therapy ☐ Botox

- Are you having any unexpected vaginal bleeding or heavy periods? ☐ Yes ☐ No
  - If yes, please answer the following questions:
    - How many pads do you use per day? _____ ▪ How many accidents do you have per day?_____
    - Do you have blood clots with your heavy periods? ☐ Yes ☐ No
    - Have you had a previous endometrial biopsy? ☐ ☐
    - Have you had any previous treatments for this? ☐ ☐
      - If yes, describe: _____
- Do you have a history of any of the following?

☐ Ovarian cysts ☐ Fibroids ☐ Heavy periods ☐ Painful periods ☐ Endometriosis

☐ Sexually transmitted disease ☐ Birth-related pelvic injury ☐ Episiotomy ☐ Forceps/Vacuum delivery

☐ Perineal laceration involving rectum ☐ Fistula ☐ Postmenopausal bleeding

ADVANCED **GYNECOLOGY**

Bladder Survey

Name:	DOB:	Today's date:

The following questions ask about your bladder and urinary function.
Please review and answer all questions as best as you can.

Do you usually experience any of the following? (**Check all that apply**)

☐ Frequent urination	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
☐ Small amounts of urine leakage (That is, drops)	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
☐ Leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
☐ Urine leakage related to coughing, sneezing, or laughing	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
☐ Difficulty emptying your bladder	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
☐ Pain or discomfort in the lower abdomen or genital region	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
☐ A sudden uncontrollable urge to urinate	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
☐ Waking up at night with the urge to urinate (nocturia)	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

- If you checked "Yes" to any of the above problems, how long have you been experiencing this?
  ☐ Less than 1 year ☐ About 1 year ☐ About 2 years ☐ 3 to 5 years ☐ Greater than 5 years

- On average, how many times do you urinate during the daytime (Waking hours)? _____
- On average, how many times do you urinate overnight (Sleeping hours)? _____
- If you leak urine, how frequently does this occur?
  ☐ Every day ☐ A few times per week ☐ A few times per month ☐ Less than once per month ☐ Never
  - If you leak urine, how much do you lose at a given time? ☐ drops ☐ Small splashes ☐ More
  - Has urine leakage caused you to feel frustrated? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Greatly
  - Do you ever leak urine while asleep? ☐ Yes ☐ No
  - Do you ever leak urine without awareness? ☐ Yes ☐ No

ADVANCED **GYNECOLOGY**

Bladder Survey

- What events trigger urine leakage? **(Check all that apply)**

  ☐ Cough ☐ Laugh ☐ Sneeze ☐ Exercise ☐ Sex

  ☐ Positional Changes ☐ Urgency ☐ Other:_____

- Have you noticed any of the following with regards to your urine stream? **(Check all that apply)**

  ☐ Slow to start (hesitancy) ☐ Weak stream ☐ Slow stream ☐ Intermittent stream

  ☐ Dribbling after stream ends ☐ Double voiding

- Do you need to do any of the following to help your bladder empty? **(Check all that apply)**

  ☐ Bearing down ☐ Pushing on lower abdomen ☐ Pushing up vaginal bulge

  ☐ Position changes ☐ Catheter usage

- Have you had a urinary tract infection (UTI) with a positive urine culture in the past year? ☐ Yes ☐ No
  - If yes, about how many have you had in the past year? _____
  - When was your most recent one (date)? _____
  - Do you think you may have one today? ☐ Yes ☐ No
- Have you noticed any blood in your urine? ☐ Yes ☐ No
- Do you have any burning or pain with urination? ☐ Yes ☐ No
- Do you ever have pain associated with a full bladder? ☐ Yes ☐ No
- Have you ever tried any medications for your bladder? (**Check all that apply**)

  ☐ Detrol/Tolterodine ☐ Ditropan/Oxybutynin ☐ Vesicare/Solifenacin ☐ Sanctura/Trospium

  ☐ Toviaz/Fesoterodine ☐ Enablex/Darifenacin ☐ Myrbetriq/Mirabegron ☐ Cardura/Flomax

  ☐ Elmiron/PPS ☐ Elmiron/PPS ☐ Methenamine/Hipprex ☐ D-Mannose ☐ Antibiotics
- Have you had any side effects from the above medications? (**Check all that apply**)

  ☐ Dry mouth ☐ Dry eyes ☐ Constipation ☐ Urine retention

  ☐ Impaired emptying ☐ Other
- Do you have any of the following medical problems?

  ☐ Glaucoma ☐ Gastroparesis/Slow GI transit ☐ Dementia

  ☐ Hypertension ☐ Myasthenia gravis ☐ QT prolongation
- Have you had any of the following treatments/procedures for your bladder?

  ☐ Sling ☐ Urethral bulking ☐ Botox in bladder ☐ PTNS ☐ PNE/Interstim ☐ Hydrodistension

  ☐ Burch/MMK procedure ☐ Pelvic floor physical therapy ☐ Other

ADVANCED **GYNECOLOGY**

Colorectal Survey

Name:	DOB:	Today's date:

The following questions ask about your bowel function.
Please review and answer all questions as best as you can.

Do you usually experience any of the following? (**Check all that apply**)

☐ The need to strain hard to have a bowel movement	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
☐ The feeling that you have not completely emptied your bowels at the end of a bowel movement	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
☐ Loss of stool beyond your control if stool is well-formed	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
☐ Loss of stool beyond your control if stool is loose	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
☐ Loss of gas from rectum beyond your control	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
☐ Pain when you pass stool	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
☐ Strong sense of urgency to have to rush to the bathroom to have a bowel movement	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
☐ Part of your bowel passing through the rectum and bulging outside during or after a bowel movement	If yes, how much does this bother you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

- If you have leakage of stool and/or gas, how often does this happen?
  ☐ Daily ☐ A few times per week ☐ A few times per month ☐ Every few months

- Do you use any pads or liners for stool leakage? ☐ Yes ☐ No
- Do you have constipation? ☐ Yes ☐ No
- Do you have hard stools that are difficult to pass? ☐ Yes ☐ No
- On average, how many bowel movements do you have a week? _____
- Do you have diarrhea? ☐ Yes ☐ No

- Have you tried any of the following medications for your bowels? **(Check all that apply)**

☐ Fiber supplementation ☐ Stool softeners ☐ Laxatives ☐ Enemas ☐ Linzess/Linaclotide

☐ Prudac/Prucalopride ☐ Xifaxin/Rifaximin ☐ Viberzi/Eluxadoline ☐ Lomotil

☐ Imodium ☐ Other_____

- Have you had any of the following treatments for bowel leakage? **(Check all that apply)**

☐ Sphincteroplasty ☐ PNE/Interstim ☐ PTNS ☐ Solesta injection ☐ Botox

☐ Artificial sphincter ☐ TOPAS ☐ Anal sphincter bulking ☐ Pelvic floor physical therapy

- When was your last colonoscopy? _____

☐ Normal ☐ Abnormal [Findings_____]

- Do you have a history of any of the following? (**Check all that apply**)

☐ Hemorrhoids ☐ Anal fissures ☐ Anal fistulas ☐ Inflammatory bowel disease

☐ Colorectal cancer ☐ Rectal prolapse ☐ IBS ☐ Slow GI motility ☐ Celiac disease

☐ Hirschsprung's disease ☐ Other_____

ADVANCED **GYNECOLOGY**

Pelvic Floor Impact Questionnaire PFIQ-7

Name:	DOB:	Today's date:

Instructions: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feelings. For each question, check the response that best describes how much your activities, relationships, or 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 chores (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 / rectum"
Pelvic Organ Prolapse Impact Questionnaire (POPIQ-7): Items under column "Pelvis / Vagina"

Scale Scores: Obtain the mean value for all of the answered items within the 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-7 Summary Score: Add the scores from the 3 scales together to obtain the summary score (range 0-300).

ADVANCED GYNECOLOGY

Physician/Patient Informed Consent & Agreement for Opioid/Narcotic Therapy for Treatment of Pain

Patient Name (LAST) _____ (FIRST) _____ (MI) _____ (Suffix) _____

Date of Birth: _____/_____/_____ Phone: _____

You may potentially receive opioid/narcotic therapy post operatively of the treatment of pain short term. It is vital that you understand these drugs are very useful but have a potential for misuse and are therefore closely controlled by local, state and federal governments.
The goal of this treatment is to:

- Reduce your pain
- Improve your level of function in performing your activities of daily living.

Our goal at Advanced Gynecology is to not initiate or continue opioid therapy whenever possible, but sometimes this may be warranted for more effective pain management.
Long term prescriptions for chronic pain will ***NOT*** be prescribed by any physician in the Advanced Gynecology practice. Any individual needing long term opioid/narcotic therapy for chronic pain will be referred to a pain management specialist.

SIDE EFFECTS

The potential side effects and risks of these medications include, but are not limited to:

- Mood changes
- Drowsiness
- Dizziness
- Constipation
- Nausea
- Confusion
- Decreased sexual function and libido (Your hormone levels can be monitored during your treatment)

Many of these side effects will resolve over days or weeks. Constipation often persists and may require additional medication. If other side effects persist, different opioids may be tried, or they may be discontinued.
You Should **NOT:**

- **Operate a vehicle or machinery**
  - Driving while taking opioids for chronic pain is considered medically acceptable as long as you do not have side effects such as sedation or altered mental status. These side effects usually do not occur while taking opioids/narcotics chronically. However, it is possible that you could be considered DUI if stopped by law enforcement while driving.
- **Consume ANY alcohol while taking opioids/narcotics**
  - The effects of alcohol and sedatives are additive with those of opioids/narcotics. If you take these substances in combination with opioids/narcotics, a dangerous situation could result, such as coma, organ damage or even ***DEATH***.
- **Take any other non-prescribed sedative medication while taking opioids/narcotics**

Patient's Initials: _____

RISKS

- **Dependence**
  - Physical dependence is an expected side effect of long-term opioid/narcotic therapy. This means that if you take opioids/narcotics continuously, and then stop them abruptly, you will experience a withdrawal syndrome. This syndrome often includes sweating, diarrhea, irritability, sleeplessness, runny nose, tearing, muscle and bone aching, gooseflesh, and dilated pupils. Withdrawal can be life-threatening. To prevent these symptoms, the opioids/narcotics should be taken regularly or, if discontinued, reduced gradually under the supervision of your physician.

- **Tolerance**
  - Tolerance to the pain-relieving effect of opioids/narcotics is possible with continued use. This means that more medication is required to achieve the same level of pain control experienced when the opioid/narcotic therapy was initiated. This may occur even though there has been no change in your underlying painful condition. When tolerance does occur, sometimes it requires tapering or discontinuation of the opioid/narcotic. Sometimes tolerance can be treated by substituting a different opioid/narcotic. When initiated, doses of medications must be adjusted to achieve a therapeutic, pain relieving effect; upward adjustments during this period are not viewed as tolerance.

- **Increased Pain (Hyperalgesia)**
  - The long-term effects of opioids/narcotics on the body's own pain-fighting systems are unknown. Some evidence suggests that opioids/narcotics may interfere with pain modulation, resulting in an increased sensitivity to pain. Sometimes individuals who have been on long-term opioids/narcotics, but who continue to have pain, note decreased pain after several weeks off the medications.

- **Addiction**
  - Addiction is a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing the development and manifestations. It is characterized by behaviors that include one or more of the following:
    - Impaired control over drug use
    - Compulsive use
    - Continued use despite harm
    - Craving

RISK TO UNBORN CHILDREN

Children born to women who are taking opioids/narcotics on a regular basis will likely be physically dependent at birth. Women of childbearing age should maintain safe and effective birth control while on opioid/narcotic therapy. Should you become pregnant, immediately contact your physician and the medication will be tapered and stopped.

LONG-TERM SIDE EFFECTS

The long-term effect of opioid/narcotic therapy is not fully known. Most of the long-term effects have been listed above. If you have additional questions regarding the potential long-term effects of opioid/narcotic therapy, please speak with your physician.

Patient's Initials: _____

PRESCRIPTIONS & USE OF OPIOID/NARCOTIC MEDICATIONS

Your medication will be prescribed by your physician for control of pain. Based on your individual needs, you will be provided prescription medication short term or post operatively.

- You agree and understand that increasing your dose without the close supervision of your physician could lead to drug overdose, causing severe sedation, respiratory depression and/or death.
- You agree and understand that opioid/narcotic medication is strictly prescribed for you, and your
- opioid/narcotic medication should NEVER be given to others.
- You agree to fill opioid/narcotic prescriptions at one pharmacy.
- You agree to secure your opioid/narcotic medications in safe, locked source to prevent loss or theft. You are responsible for any loss of theft.
- You agree that lost, stolen or destroyed prescriptions or drugs will not be replaced, and may result in discontinuation of treatment.
- You agree to obtain opioid/narcotic medication from one prescribing physician or that physician's substitute if your prescribing physician is not available and your prescribing physician has authorized his or her substitute to provide treatment.
- You agree to submit to blood and/or urine testing to monitor the levels of medication or other drugs and any organ side effects. You also agree that other doctors and law enforcement may be notified of the results.
- You understand and agree that if you lose your medication or run out early due to overuse, you may experience and go through withdrawal from opioids/narcotics. You further understand and agree that you are solely responsible for your own medications.
- You agree to provide a list from your pharmacy detailing all medications received from that pharmacy and to provide updated lists as requested by your physician.

For patients taking methadone: Methadone has significant interactions with many other medications. Some of these medications may reduce your body's ability to metabolize methadone, thus INCREASING the methadone in your body, which could be dangerous. Therefore, you MUST notify this office of ALL medications prescribed for ANY condition while taking methadone.

OPIOID/NARCOTIC THERAPY MAY BE DISCONTINUED IF YOU:

- Develop progressive tolerance which cannot be managed by changing medications
- Experience unacceptable side effects which cannot be controlled
- Experience diminishing function or poor pain control
- Develop signs of addiction
- Abuse any other controlled substance (this may be determined by random blood/urine testing)
- Obtain and or use street drugs (this may be determined by random blood/urine testing)
- Increase your medication without the consent of your physician
- Obtain opiates/narcotics from other physicians or sources
- Fill prescriptions at other pharmacies without explanation
- Sell, give away, or lose medications
- Violate any of the terms of this agreement

Patient's Initials: _____

Physician/Patient Informed Consent & Agreement for Opioid/Narcotic Therapy for Treatment of Pain

BY SIGNING BELOW, I ACKNOWLEDGE AND AGREE TO THE FOLLOWING:

- I have read and fully understand the Physician/Patient Informed Consent and Agreement for Opioid/Narcotic Therapy for the Treatment of Pain
- I have been given the opportunity to ask questions about the proposed treatment (including no treatment), potential risks, complications, side effects, and benefits
- I knowingly accept and agree to assume the risks of the proposed treatment as presented
- I agree to abide by the terms of this agreement

_____	_____	_____
Patient Name (Please Print Clearly)	Patient Signature	Date
_____	_____	_____
Witness Name (Please Print Clearly)	Witness Signature	Date
_____	_____	_____
Physician Name (Please Print Clearly)	Physician Signature	Date