Jefferson

833 Chestnut Street, Concourse
Philadelphia, PA 19107
T 215-955-5000
F 215-923-1089

COMPREHENSIVE UROGYNECOLOGY

AND FEMALE PELVIC MEDICINE

833 Chestnut Street Philadelphia, PA 19107

2130 Spring Garden Street, Philadelphia, PA 19123

3 Crescent Drive Philadelphia, PA 19112

Phone 215-955-5000 Fax 215-955-7366

Karolynn Echols, M.D., FACOG, FPMRS, FABOIM

Reneita Ross, M.D., FACOG, FPMRS

Andrea Martin, DNP, CRNP, WHNP

Welcome to Thomas Jefferson University Urogynecology, a division of the Obstetrics and Gynecology Department. We are pleased you chose our office for your urogynecological needs. In order to ensure that your appointment addresses all of your medical needs, please arrive **30 minutes** prior to your appointment. We also ask that you complete the paperwork in this packet (pages are double-sided) and bring it to your visit.

Please be advised there is a 3-day bladder journal that must be completed if you have urinary or bladder complaints. It is located in the back of this packet.

Important information regarding our Practice

- Because Urogynecology is a subspecialty, some insurances require a referral and/or authorization. Please contact your Primary Care Physician (PCP) at least one (1) week prior to your appointment to obtain a referral/authorization. If you have not seen your PCP in a year, they may require you to make an appointment in order to obtain a referral.

- Please bring your insurance card, Photo identification, copay and referral to your appointment. If you have any billing questions regarding your visit, please contact our billing department by calling 215-955-5000. Please press option 4, then option 3 to be connected to a billing specialist.

- **Canceling /Rescheduling:** In an effort to meet the high demand of patient volume, we ask that you cancel or reschedule your appointment at least 24 hours prior to the scheduled appointment time. This allows the department to accommodate a patient that is waiting for an appointment.

- **Late Arrivals**: Please know there is a fifteen (15) minute grace period for arrived appointment times. If you arrive more than 15 minutes past your appointment time, you will be asked to reschedule.

- **Records:** We ask that previous records be faxed to our office prior to your appointment. The fax number is 215-955-7366. The medical release has been provided in this packet to obtain your records from your referring provider.

- **Medications:** Please bring all medications, prescriptions, herbal supplements, vitamins, etc. that you take on a regular basis to your first appointment.

- **Jeff MyChart:** Jefferson Health offers patients the ability to view a portion of your medical records through Jeff MyChart. You are able to request prescription refills, view test results and communicate electronically and securely with your medical care team.

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About Our Program

Our practice in Comprehensive Urogynecology and Female Reconstructive Pelvic Medicine and Surgery (FRPMS), also known as "Urogynecology" is a specialty devoted to female bladder, bowel and other pelvic conditions. Our goal is to provide you with the most advanced care for these important and often-neglected women's health problems, while making the process as comfortable and efficient as possible. Our commitment to research provides unique access to cutting edge technologies including medications and new surgical innovations, and our physicians are leading researchers, educators and innovators in this field. Additionally, our technology platform here at Thomas Jefferson University Hospital is second to none: including an advanced data-tracking system that allows us to monitor and constantly improve our outcomes, which provides every patient with secure messaging communication with our office and access to medical results from a computer or smartphone.

Our Team

Karolynn Echols, M.D., FACOG, FPMRS, FABOIM – Dr. Echols is the Section Chief and Associate Professor of Female Pelvic Medicine and Reconstructive Surgery at Thomas Jefferson University. She received her B.S. Degree in Electrical Engineering from Cornell University and her M.D. degree from Temple University School of Medicine. She completed her OBGYN residency at the University of Miami/ Jackson Memorial Hospital and her fellowship in Female Pelvic Medicine and Reconstructive Surgery at the Louisiana State University Health Sciences Center in New Orleans. Dr. Echols has received numerous awards for invaluable research, education and teaching at the local, national and international levels. Dr. Echols has almost 20 years' experience in Urogynecology, with a special interest in Integrative Medicine as it applies to the field and is well regarded in the Philadelphia/Southern New Jersey community, earning numerous accolades for her quality and patient-centered care. As the president and co-founder of Medicine in Action, a 501c-3 organization that provides medical and surgical care to women and children, Dr. Echols and her team travel extensively to resource-limited areas worldwide. In 2016, she most recently completed a fellowship in Integrative Medicine with Dr. Andrew Weil and other renowned faculty in the field at the Arizona Center for Integrative Medicine and is currently board-certified in the field.

Reneita Ross, M.D., FACOG, FRMRS – Dr. Ross is one of the region's Board-Certified, fellowship-trained Urogynecologists. Dr. Ross attended the University of Wisconsin where she received her medical degree and completed a residency program in Obstetrics and Gynecology. She was selected for subspecialty fellowship training at Emory University in Urogynecology/Female Pelvic Medicine and Reconstructive Surgery. Dr. Ross has been practicing for over 12 years in the conservative and surgical management of urinary incontinence, pelvic organ prolapse, chronic pelvic/bladder pain and sexual dysfunction. With an emphasis on Urinary Incontinence, and an expertise in Chronic Pelvic/Bladder Pain and Sexual Health Issues, Dr. Ross provides a comprehensive approach including evaluation and treatment of pelvic floor disorders.

Andrea Martin, DNP, CRNP – Andrea is a Certified Registered Nurse Practitioner. She received a B.S. from Rutgers University in Animal Sciences, as well as a B.S.N. from William Paterson University. She received her M.S.N. in Women's Health from Rutgers University and received her Doctorate of Nursing Practice Degree from Misericordia University. She has worked for over ten years in Pennsylvania and New Jersey hospitals as medical surgical and telemetry nurse, where she earned a DAISY award nomination for excellence in patient care. She also worked as a Nurse Practitioner in a New Jersey family clinic. Andrea strives to provide the atmosphere of approachability and trust and looks forward to providing exceptional care.

Shalane Smith, CMA, Urogynecology Navigator – Shalane is an essential part of our team as she focuses primarily on patients' needs and coordination of services, to ensure the patient has an outstanding customer service experience. Shalane helps to meet the needs of the patient and works to expedite treatment and services. She assists in all aspects of patient care and ensures a comfortable patient experience during visits. Shalane has worked in Women's Health for over a decade and is extremely knowledgeable in Urogynecology in addition to general obstetrics, gynecology and high risk maternal fetal medicine.

Thomas Jefferson University Health Care

Urogynecology Initial Visit Questionnaire

Name: _____ Date of Birth: _____

Referring Physician:

Name _____

Address _____

Phone _____

Fax _____

Primary Physician:

Name _____

Address _____

Phone _____

Fax _____

Gynecologist:

Name _____

Address _____

Phone _____

Fax _____

Other Physician(s):

Name _____

Address _____

Phone _____

Fax _____

Emergency Contact:

Name _____

Address _____

DIRECTIONS TO JEFFERSON HEALTH

From the Pennsylvania Turnpike

Exit at Valley Forge. Take Rt. 76 East to I-676 East to the 8th Street/Chinatown Exit. Take 8th Street across Market Street to Central PARK Garage (on Left) immediately after Ranstead Street.

From I-95 North of Wilmington

Take Exit 22 Independence Hall/Callowhill Street following signs for Callowhill Street. Proceed on Callowhill to 8th Street (south). Turn left onto 8th. Take 8th Street across Market Street to Central PARK Garage (on Left) immediately after Ranstead Street.

From I-95 South (From Bucks County)

Take Exit 22 Independence Hall/Callowhill Street, following signs for Callowhill Street. Proceed on Callowhill to 8th Street (south). Turn left onto 8th. Take 8th Street across Market Street to Central PARK Garage (on Left) immediately after Ranstead Street.

From New Jersey Shore Points

Take the Atlantic City Expressway North to Rt. 42 North. Follow signs for the Benjamin Franklin Bridge (toll). Get into the extreme LEFT lane and follow signs for 8th Street/Chinatown. Turn left onto 8th. Take 8th Street across Market Street to Central PARK Garage (on Left) immediately after Ranstead Street.

From New York and North New Jersey

Take the New Jersey Turnpike South to Exit 4/Rt. 73 North. Take Rt. 73 North to Rt. 38 West. Follow Rt. 38 West to the Benjamin Franklin Bridge. Cross over the Benjamin Franklin Bridge (toll). Get into the extreme LEFT lane and follow signs for 8th Street/Chinatown. Turn left onto 8th. Take 8th Street across Market Street to Central PARK Garage (on Left) immediately after Ranstead.

From Central PARK Garage to office:

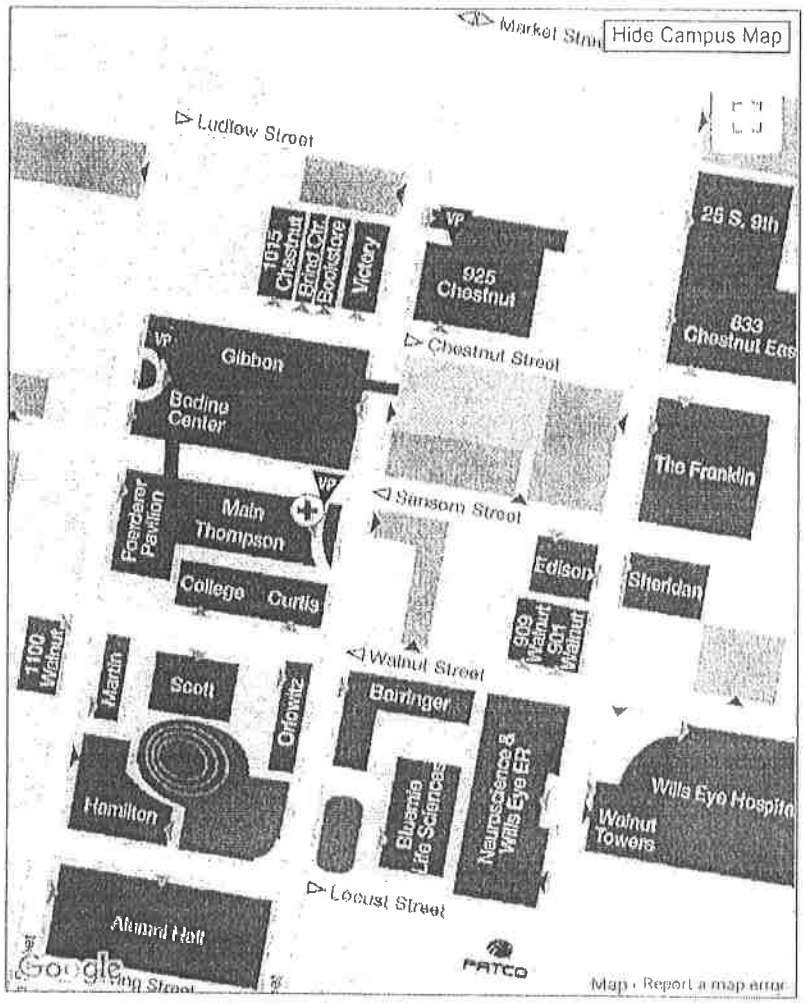
Walk on Chestnut Street towards 8th, cross 8th and the OB/GYN office is approx. 1/8 block from 8th Street corner. Entrance is under ornamental gold overhang.

Parking Areas

Please ask the front desk for a stamp/coupon for discount parking.

Central Park Garage—enter from 8th or Chestnut Street (discounted parking coupon)

Benjamin Franklin Parking (underground—Located at the Benjamin Franklin)—Enter Sansom Street between 8th and 9th Streets ($14 Per Day)



Campus Locations

1015 Chestnut
1100 Walnut Medical Office Building
25 South 9th
833 Chestnut East (Side Entrance)
833 Chestnut East (Front Entrance)
901 Walnut Health Professions Academic Building
909 Walnut Clinical Office Building
925 Chestnut (Front Entrance)
925 Chestnut (Side Entrance)
Alumni Hall
Barringer Residence Hall
Bluemle Life Sciences Building
Bodine Center for Radiation Therapy
College Building
Curtis Building
Edison Building
Emergency Department at Jefferson
Emergency Department at Wills Eye Hospital
The Franklin (Front Entrance)
The Franklin (Side Entrance)
Gibbon Building (Back Entrance)
Gibbon Building (Front Entrance)
Dorrance H. Hamilton Building
Jefferson Hospital for Neuroscience
Jefferson Medical & Health Science Bookstore
Jefferson-Myrna Brind Fitness & Lifestyle Programs
Main Building
Martin Residence Hall
Orlowitz Residence Hall
Scott Memorial Library
Sheridan Building
Walnut Towers - 9th Street Entrance
Walnut Towers - Walnut Street Entrance
Victory Building

Map Legend

- Emergency Room
- Building Entrance
- Parking Lot Entrance
- Valet Parking Location

Our interactive map allows you to locate specific buildings on our Center City campus and plot directions from one location to the next.

- Find the building you are looking for in the list to the right
- Click on the building name, a photo of the building entrance will appear
- Select "directions to" or "directions from"
- Either type in another address or select another location from the list

Jefferson
at the Navy Yard

From Center City

By Car

Take Broad Street south to the Navy Yard. Enter the Navy Yard and turn left at first light onto Crescent Drive.

By SEPTA

Take the Broad Street Subway (Orange Line) south to Pattison Avenue.

Take Bus #71 on the Southeast corner of Broad Street to the Navy Yard.

Exit at Crescent Drive.

From New Jersey via Walt Whitman Bridge

Cross the Walt Whitman Bridge.

After the toll booth, take Exit 349 (Broad Street/Sports Complex).

Turn left at the first light onto Broad Street.

Follow Broad Street approximately one mile to the Navy Yard.

Enter the Navy Yard and turn left at the first light onto Crescent Drive.

From Delaware and Points South of Philadelphia

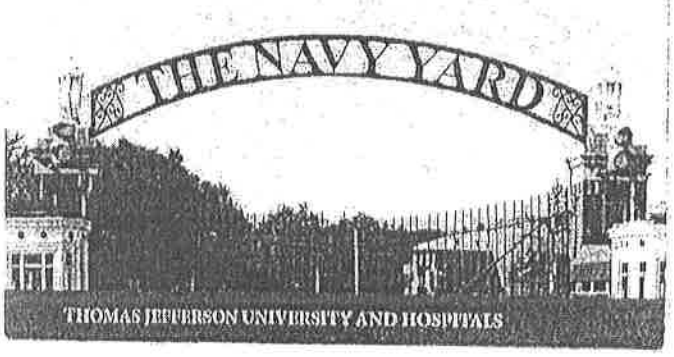
Take I-95 North to Exit 17 (Broad Street/Pattison Avenue).

Turn left at first light (Zinkoff Boulevard) and make immediate left onto Broad Street.

Get in right lane (avoid the entrance to I-95) and follow Broad Street into the Navy Yard.

Enter the Navy Yard and turn left at the first light onto Crescent Drive.

continued on back



From Points North

Take I-95 South to Exit 17 (Broad Street/Pattison Avenue).

Stay to the left.

Cross over Broad Street and then make a left onto Broad Street at the second light.

Enter the Navy Yard and turn left at the first light onto Crescent Drive.

From the Western Suburbs

Take 476 South to I-95 North.

Take I-95 North to Exit 17 (Broad Street/Pattison Avenue).

Turn left at the first light (Zinkoff Boulevard) and make an immediate left onto Broad Street.

Get in right lane (avoid the entrance to I-95) and follow Broad Street into the Navy Yard.

Enter the Navy Yard and turn left at the first light onto Crescent Drive.

Parking

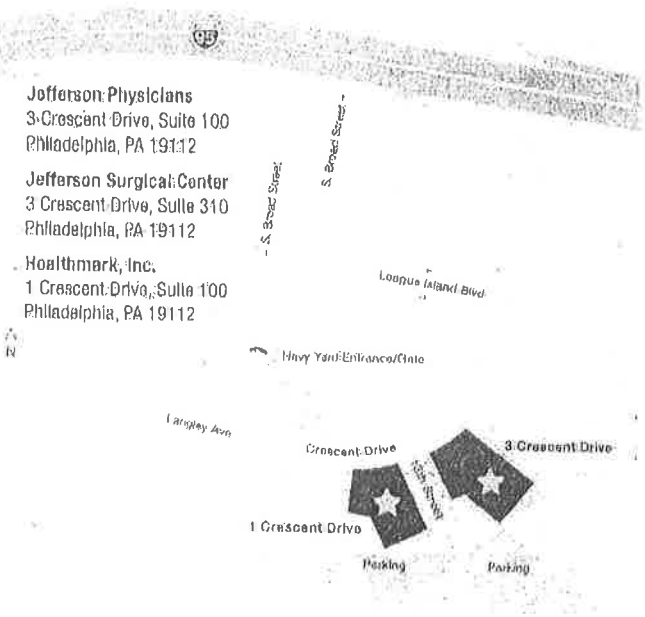
Free parking is available. The parking lot is located behind 3 Crescent Drive. Turn right at the stop sign and make the next right into the parking lot.

For more information about Jefferson at the Navy Yard, call 1-800-JEFF-NOW or visit us online at www.JeffersonHospital.org/navyyard

Jefferson Physicians
3 Crescent Drive, Suite 100
Philadelphia, PA 19112

Jefferson Surgical Center
3 Crescent Drive, Suite 310
Philadelphia, PA 19112

Healthmark, Inc.
1 Crescent Drive, Suite 100
Philadelphia, PA 19112



Phone _____ Fax _____

Relationship _____

Pharmacy Information:

Retail Pharmacy

Name _____

Address _____

Phone _____ Fax _____

Mail Order Pharmacy:

Name _____

Address _____

Phone _____ Fax _____

Laboratory Information:

Is there a particular laboratory that your Health Insurance requires you to use? YES / NO

If yes, please list: _____

Radiology Information:

Is there a particular radiology group or service that your Health Insurance requires you to use?

YES / NO

If yes, please list: _____

Communication of Protected Health Information

I would like Jefferson University Physicians ("Jefferson") to share my protected health information, which includes billing information with the individuals listed below. After providing Jefferson with this completed and signed form, Jefferson agrees to communicate with the individuals listed below unless I provide Jefferson with written notice to no longer do so.

Patient Name: _____ DOB: _____

I hereby grant Jefferson's Department of OB/GYN permission to communicate my protected health information to the following individuals:

Name _____

Address _____

Phone _____ Relationship: _____

Name _____

Address _____

Phone _____ Relationship: _____

Name _____

Address _____

Phone _____ Relationship: _____

I understand that completing this form is voluntary. I am not required to list any individuals.

Patient Signature: _____ Date: _____

Please list if and how the Department of OB/GYN can leave or send you detailed messages regarding your health information and/or care if necessary.

Can we leave a detailed message? **YES / NO**

If yes, by what method (please circle answer)?

VOICEMAIL **PHONE** **EMAIL**

Phone Number: _____

Email: _____

I understand that completing this information is voluntary.

Patient Signature: _____

Date: _____

Jefferson.

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MEDICATIONS

List all medications, including over the counter vitamins and herbal supplements. Please bring all medications to your first office visit.

START	MEDICATION	DOSAGE	FREQUENCY

MEDICAL HISTORY

Please circle all that apply:

Gynecological: severe pain or emotion with periods / abnormal pap / abnormal uterine bleeding / breast cancer / cervical cancer / vitamin D deficiency / endometriosis / fibroids / menopause / ovarian cancer / ovarian cyst / painful periods / pelvic pain / PID / postmenopausal bleeding / prolapse / STD / uterine cancer / vulvar cancer / other not listed/ pain or bleeding with sex / stomach or bowel pain problems / hormonal problems

Urological: bladder infection / bladder stones / chronic kidney disease / pain or bleeding with urination / interstitial cystitis / kidney cancer / kidney stones / renal cell carcinoma / urinary incontinence / urinary frequency / urinary urgency / urine leakage

Gastrointestinal: anal incontinence / chronic constipation / colon cancer / inflammatory bowel disease / irritable bowel syndrome/ liver disease / other

Cardiac/Pulmonary: asthma / blood clots / coronary artery disease / chronic cough / COPD / emphysema / heart failure / high cholesterol / high blood pressure / stroke / others not listed

Neurological/ Musculoskeletal: back injury / back pain / fibromyalgia / herniated disc / multiple sclerosis / neuropathy / Parkinson's disease / sciatica / spinal stenosis / other not listed

Endocrine/General: anxiety / cancer / depression / diabetes / glaucoma / thyroid disease / other

Please describe any medical history not listed above:

_____

_____

SURGICAL HISTORY

Have you had any surgeries in the past: YES / NO

If YES please circle the type of surgery: abdominal (appendix, gallbladder, liver, etc.) / abdominal hysterectomy / breast / cardiac (heart) / cervical (leep, cone, etc.) / cesarean section / cystoscopy / D & E / hernia repair / intestinal / kidney / laparoscopic / laparoscopic hysterectomy / lung / ovarian cyst / oophorectomy (left/right/both) / pelvic organ prolapse / rectal / robotic / robotic hysterectomy / thyroid / surgical repair with mesh / urinary incontinence / other not listed

Please list any surgeries not listed above and dates of all surgeries:

_____

_____

ALLERGIES

Do you have any drug allergies: YES / NO

Do you have any other type of allergies: YES / NO

Do you have a Latex Allergy: YES / NO

Do you have an allergy to betadine or iodine: YES / NO

If yes to any of the above, please list all drug allergies and/or other allergies and reactions if exposed:

_____

_____

_____

OBSTETRICAL HISTORY

Year	Miscarriage (✓)	Abortion (✓)	Ectopic Pregnancy (✓)	Vaginal Delivery (✓)	Cesarean Delivery (✓)	Weight Of Baby	Weeks Pregnant at Delivery	Complications

GYNECOLOGICAL HISTORY

Currently sexually active: YES / NO

How many partners: ONE / MULTIPLE / OTHER

What type of partner: MALE / FEMALE / BOTH

Birth Control: YES / NO / NOT APPLICABLE

If yes, what type of birth control? _____

Are you satisfied with your birth control method? YES / NO / NOT APPLICABLE

Do you plan to have children in the future? YES / NO / UNDECIDED / NOT APPLICABLE

Are you interested in being tested for HIV and/or STDs (gonorrhea, chlamydia, syphilis, hepatitis, and herpes)? YES / NO

When was your last Pap smear? _____

Was it normal? YES / NO

If not, what further testing did you have? _____

_____

Age of your first menstrual period _____

First day of your LAST menstrual period _____

Periods occur every _____days. Number of days of menstrual flow _____

Are your periods: LIGHT / MODERATE / HEAVY (circle one)

Do you ever miss periods? YES / NO

Do you ever bleed in between periods? YES / NO

Do you take medicine for painful periods? YES / NO

If you are menopausal, have you had a bleeding since menopause? YES / NO

Have you ever had a DEXA scan? YES / NO

If yes, when was scan completed? _____

If yes, were the results normal? YES / NO

If results were abnormal, what were the results and what was the treatment plan?

_____

_____

Have you ever had a mammogram? YES / NO

If yes, when was your last mammogram? _____

Were the results normal? YES / NO

If results were abnormal what were the results and what was the treatment plan?

_____

_____

Have you ever had a colonoscopy? YES / NO

If yes, when was your last colonoscopy? _____

Were the results normal? YES / NO

If the results were abnormal, what were the results and what was the treatment plan?

_____

_____

FAMILY HISTORY

Any of the following relatives have/had these diseases? Please ✓

Relationship	Cancer	Liver Disease	Lung Disease	Renal Disease	Heart Disease	Thyroid Disease	Hyper-tension	Elevated Lipids	Diabetes	Musclo Skeletal Disease	Osteo porosis
Mother											
Father											
Sister											
Brother											
Maternal Grandmother											
Paternal Grandmother											
Maternal Grandfather											
Paternal Grandfather											

SOCIAL HISTORY

Alcohol: YES / NO

If yes, what type of alcohol and how much? _____

Illicit Drug Use: YES / NO

If yes, what type of drugs and how often? _____

Smoking:

Current Smoker: YES / NO (cigarettes, cigars, chewing, pipe, vaporizers)

If yes, what type and how many packs per day? _____

_____

Former Smoker: YES / NO If yes, when did you quit? _____

If yes, how many packs a day? _____

Briefly explain your diet:

_____

Are you meeting your nutritional requirements? YES / NO

If not, why not? _____

Do you have any vitamin deficiencies? YES / NO

If yes, what are they? _____

Do you exercise? YES / NO If yes, how often per week? _____

_____

REVIEW OF SYSTEMS

Are you **CURRENTLY** experiencing any of the following? (Circle all that apply)

Fever / chills / headache / swollen glands / blurred vision / double vision / eye pain / sinus problems / frequent nose bleeds / seasonal allergies / food allergies / drug allergies / contact allergies

Tremors / dizziness / numbness or tingling / pain / muscle weakness / joint pain / back pain / excessive thirst / excessive lethargy / excessive urination / abdominal pain / nausea / vomiting / heartburn / blood in stool

Chest pain / varicose veins / swelling in legs / easy bruising / wheezing / shortness of breathe / frequent cough / pain while breathing

Depression / anxiety / other psychological illness / skin rash / persistent itch / patchy skin / open wounds

Other: _____

_____

_____

Which of the following symptoms are bothering you? Circle all that apply:

Urinary: urinary incontinence / urinary pain or burning / frequent urination / frequent bladder infection / night time voiding / difficulty emptying bladder / urgency to urinate

Vaginal: vaginal and/or uterine prolapse / vaginal dryness / vaginal pain / vaginal itching / vulvar itching / vaginal bleeding / vaginal discharge

Bowel: accidents involving stool / accidents involving gas / constipation

Sexual: decreased satisfaction / painful intercourse

Pain: pelvic pain / bladder pain / rectal pain / abdominal pain / back pain

Others not listed: _____

_____

Which **ONE** symptom above is the **MOST** bothersome to you?

_____

How long have these problems been present? Please circle:

Less than 1 month

1 – 6 months

6 – 12 months

1 – 2 years

3 – 5 years

6 – 10 years

More than 10 years

Have you had any treatments for the problem (s)? YES / NO

If yes, please indicate by circling any and all treatments previously received:

Overactive bladder medication

Antibiotics for frequent bladder infections

Kegel exercises

Physical therapy for the pelvic floor

Vaginal Estrogen Therapy

Surgery for Prolapse (vaginal bulge)

Medical for pelvic or vaginal pain

Pessary device

Stool Softeners

Laxatives

Botox (for bladder or pelvic symptoms)

Urethral Injections

Bladder Instillations (medicine put into the bladder)

Other: _____

What are your goals in seeking our help (please circle all that apply):

Improve my bladder control

Decrease daytime urination

Reduce urinary (bladder) infections

Fix my prolapse (vaginal bulge)

Reduce my vaginal prolapse symptoms

Improve my bowel control

Reduce constipation and difficulty having bowel movements

Improve sexual function

Reduce pain in pelvis, bladder and/or vagina

Other: _____

How often are you urinating (# of hours between daytime voids)?

Please circle response

Less than 1 hour 2 hours 3 hours 4 hours More than 5 hours

How many times do you wake up at night to urinate? Please circle response

0 1 2 3 4 5 More than 5

How often do you leak urine? Please circle response

Never / once a week or less / 2-3 per week / once a day / several times per day/ Always

How much urine do you usually leak – whether you wear protection or not.

None / small amount / moderate amount / large amount

During average day, how many pads or diapers do you use? **Please circle response**

0 1- 2 3-4 More than 5

How much does leaking urine interfere with your everyday life? **Please circle a number between 0 (not at all) and 10 (a great deal)**

0 1 2 3 4 5 6 7 8 9 10

When does urine leak? Please circle all responses that apply

Never –urine does not leak / leaks when coughing or sneezing / leaks when physically active / leaks before you can get to the toilet / leaks when sleeping / leaks when standing up after urinating / leaks for no obvious reason / leaks all the time

Circle category that best describes how your urinary symptoms are now

Normal Mild Moderate Severe

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Urogynecology Questionnaires

Pelvic Floor Distress Inventory Questionnaire

Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder or pelvic symptoms and if you do how much they bother you. Answer each question by putting an X in the appropriate boxes. If you are unsure how to answer, please give the best answer you can. While answering these questions, please consider your symptoms over the **last 3 months.** If YES, how much does it bother you?

	Not at all	Somewhat	Moderately	Quite a Bit
Do you usually experience pressure in the lower abdomen?				
Do you usually experience heaviness or dullness in the lower abdomen?				
Do you usually have a bulge or something falling out that you can see or feel inn the vagina area?				
Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?				
Do you usually experience a feeling of incomplete bladder emptying?				
Do you ever have to push up in the vaginal area with your fingers to start or complete urination?				
Do you feel you need to strain too hard to have a bowel movement?				
Do you feel you have not completely emptied your bowels at the end of a bowel movement?				
Do you usually lose stool beyond your control if your stool is loose or liquid?				
Do you usually lose gas from the rectum beyond your control?				
Do you usually have pain when you pass your stool?				
Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement? Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?				

Do you usually experience frequency of urination?				
Do you usually experience urine leakage related to laughing, coughing or sneezing?				
Do you usually experience small amounts (drops) of urine leakage?				
Do you usually experience difficulty emptying your bladder?				
Do you usually experience pain or discomfort in the lower abdomen or genital area?				

This questionnaire asks about how much you have been bothered by selected bladder symptoms during the past 4 weeks. Please place a ✓ in the box that best describes the extent to which you were bothered by each symptom during the past 4 weeks. There are no right or wrong answers. Please be sure to answer every question.

During the past 4 weeks, how bothered were you by …	**Not at All**	**A little bit**	**Somewhat**	**Quite a bit**	**A great deal**	**A very great deal**
An unforgettable urge to urinate?						
A sudden urge to urinate with little or no warning?						
Accidental loss of small amounts of urine?						
Nighttime Urination?						
Waking up at night because you had to urinate?						
Urine loss associated with a strong desire to urinate?						

OAB - Q QUESTIONNAIRE

This questionnaire asks about how much you have been bothered by selected bladder symptoms during the past 4 weeks. Please place a √ or an **X** in the box that best describes the extent to which you were bothered by each symptom during the! past 4 weeks. There are no right or wrong answers. Please be sure to answer every question.

During the past 4 weeks, how bothered were you by. . .	Not at all	A little bit	Some-what	Quite a bit	A great deal	A very great deal
1. An uncomfortable urge to urinate?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
2. A sudden urge to urinate with little or no warning?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
3. Accidental loss of small amounts of urine?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
4. Nighttime urination?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
5. Waking up at night because you had to urinate?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
6. Urine loss associated with a strong desire to urinate?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

Sexual Function Questionnaire (PISQ-12)

The next set of items covers material that is sexual and personal. Specifically, these questions ask about matters related to your sexual activity in the past month. We realize that for some women, sexual activity is an important part of their lives; but for others it is not. To help us understand how your bladder and pelvic programs might affect your sexual activity, we would like you to answer the following questions from your own personal viewpoint.

While we hope you are willing to answer all of these confidential questions, if there are any questions you would prefer not to answer, you are free to skip them. Please select the most appropriate response to each question. Remember these questions are only relevant to sexual activity in the **PAST MONTH**.

In the past month, have you engaged in sexual activity with a partner?

☐ Yes → complete only Section A below

☐ No → complete only Section B below

SECTION A: If you **have** engaged in sexual activity with a partner in the last month:

1. How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex, feeling frustrated due to a 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 sexual 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 (the bladder, rectum, or vagina)?

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 orgasms you have had in the past month?

Always	Usually	Sometimes	Seldom	Never

SECTION B: If you have not had sexual activity with a partner in the last month

1. Do you have a partner at this time? YES / NO

2. How frequently do you feel sexual desire? The feeling may include want to have sex, planning to have sex, feeling frustrated due to a lack of sex, etc.

Always	Usually	Sometimes	Seldom	Never

3. How satisfied are you with the variety of sexual activities in your current sex life?

Always	Usually	Sometimes	Seldom	Never

4. Does fear of pain during sexual intercourse restrict your activity?

Always	Usually	Sometimes	Seldom	Never

5. Does fear of incontinence (either stool or urine) during sexual intercourse restrict your sexual activity?

Always	Usually	Sometimes	Seldom	Never

PCS

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscular pain. People are often exposed in situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

0 – Not at all 1 – to a slight degree 2- to a moderate degree 3 – to a great degree 4 – all the time

When I'm in pain …

1. ___ I worry all of the time about whether the pain will end
2. ___ I feel I can't go on.
3. ___ It's terrible and I think it's never going to get any better
4. ___ It's awful and I feel it overwhelms me.
5. ___ I feel I can't stand it anymore.
6. ___ I become afraid that the pain will get worse.
7. ___ I keep thinking of other painful events.
8. ___ I anxiously want the pain to go away.
9. ___ I can't seem to keep it out of your mind.
10. ___ I keep thinking about how much it hurts.
11. ___ I keep thinking about how badly I want the pain to stop.
12. ___ There's nothing I can do to reduce the intensity of the pain.
13. ___ I wonder rather something serious may happen.

……. Total

Jefferson.

833 Chestnut Street, Concourse
Philadelphia, PA 19107
T 215-955-5000
F 215-923-1089

Pelvic Pain Questionnaire (PRE PROCEDURE)

Female NIH – Symptom Index (NIH-CPSI

National Institutes of Health

Name: _____ Date: _____

Pain or Discomfort

1. In the last week, have you experienced any pain or discomfort in the following areas:

a. Area between the rectum and vagina (Perineum)	Yes	No
b. Labia	Yes	No
c. Clitoris (not related to urination)	Yes	No
d. Below your waist, in your pubic or bladder area	Yes	No
e. Below your waist in your rectal area	Yes	No

2. In the last week, have you experienced:

a. Pain or burning during or after urinating.	Yes	No
b. Pain or discomfort during or after sexual climax	Yes	No

3. How often have you had pain or discomfort in any of these areas over the last week

0. Never
1. Rarely
2. Sometimes
3. Often
4. Usually
5. Always

4. Which number best describes your AVERAGE pain or discomfort on the days that you had it over the last week?

0 1 3 4 5 6 7 8 9 10

↑ No pain

↑ Pain as bad Bad as you can imagine

Litwin, et al., J Urol. 1999; 162:369-375.

Pelvic Pain Questionnaire (PRE PROCEDURE)

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2. In the last week, have you experienced:

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b. Pain or discomfort during or after sexual climax	Yes	No

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1. Rarely
2. Sometimes
3. Often
4. Usually
5. Always

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0 1 3 4 5 6 7 8 9 10

↑ No pain

↑ Pain as bad Bad as you can imagine

Litwin, et al., J Urol. 1999; 162:369-375.

Urination

5. How often have you had a sensation of not emptying your bladder completely after you finished urinating over the last week?

   0 Not at all
   1 Less than 1 time in 5
   2 Less than half the time
   3 About half the time
   4 More than half the time
   5 Almost always or always

6. How often have you had to urinate again less than 2 hours after you finished urinating over the last week?

   0 Not at all
   1 Less than 1 time in 5
   2 less than half the time
   3 About half the time
   4 More than half the time
   5 Almost always

Impact of symptoms

7. How much have your symptoms kept you from doing the kinds of things you would usually do over the last week?

   0 None
   1 Only a little
   2 Some
   3 A lot

8. How much did you think about your symptoms, over the last week?

   0 None
   1 Only a little
   2 Some
   3 A lot

9. If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?

   0 Delighted
   1 Pleased
   2 Mostly satisfied
   3 Mixed (about equally satisfied and dissatisfied)
   4 Mostly dissatisfied
   5 Unhappy
   6 Terrible

Litwin, et al., J Urol. 1999; 162:369-375.

1. Describe your average quality of life before treatment.

0 1 3 4 5 6 7 8 9 10

↑ Terrific

↑ Absolutely

2. What recent treatment(s) (within a year) have you tried?

    1. Trigger point injection with steroids
    2. Medication _____
    3. Pelvic Floor Therapy
    4. Osteopathic Manipulation
    5. Pudendal nerve block with steroid
    6. Acupuncture
    7. Bladder treatments_____

3. Have you had any repeat treatment(s)?
    1. Yes
    2. No

4. If yes, what were they?

    1. Trigger point injection with steroids
    2. Medication _____
    3. Pelvic Floor Therapy
    4. Osteopathic Manipulation
    5. Pudendal nerve block with steroid
    6. Acupuncture
    7. Bladder treatments_____

Litwin, et al., J Urol. 1999; 162:369-375.

COMPREHENSIVE UROGYNECOLOGY AND FEMALE PELVIC MEDICINE

Bladder & Voiding Journal – 72 hour

If experiencing any type of urinary/bladder issues or symptoms (pain with urination, urgency, frequency, leaking of urine, incontinence, etc), this bladder diary must be completed before the initial visit and please be sure to bring this with the new patient packet. Any questions about the journal, please call 215-955-000 and ask for the Uro-Gyn Navigator.

Your Name: _____

Date: ____/____/_____ through ___/_____/_____

Day 1

TIME	DRINKS What kind? How much?	TRIPS TO THE BATHROOM	Accidental Leaks How much? Circle one	Do you feel a strong urge to go? Circle one	What were you doing at the time? Sneezing, exercising, having sex, lifting,etc.
SAMPLE	Coffee 2 cups	✓✓ sm med lrg	Sm med lrg	YES NO	Running
6 – 7 AM			Sm med lrg	YES NO	
7 – 8AM			Sm med lrg	YES NO	
8 – 9AM			Sm med lrg	YES NO	
9 – 10AM			Sm med lrg	YES NO	
10 – 11AM			Sm med lrg	YES NO	
11 – 12PM			Sm med lrg	YES NO	
12 – PM			Sm med lrg	YES NO	
1 – 2PM			Sm med lrg	YES NO	
2 – 3PM			Sm med lrg	YES NO	
3 – 4PM			Sm med lrg	YES NO	
4 – 5PM			Sm med lrg	YES NO	
5 – 6PM			Sm med lrg	YES NO	
6 – 7PM			Sm med lrg	YES NO	

I used _____pads today. I used _____ diapers today (write #)

Day 1

TIME	DRINKS What kind? How much?	TRIPS TO THE BATHROOM	Accidental Leaks How much? Circle one	Do you feel a strong urge to go? Circle one	What were you doing at the time? Sneezing, exercising, having sex, lifting,etc.
SAMPLE	Coffee 2 cups	✓✓ sm med lrg	Sm med lrg	YES NO	Running
7 -8PM			Sm med lrg	YES NO	
8 -9PM			Sm med lrg	YES NO	
9 – 10PM			Sm med lrg	YES NO	
10 – 11PM			Sm med lrg	YES NO	
11 – 12AM			Sm med lrg	YES NO	
12 -1AM			Sm med lrg	YES NO	
1 -2AM			Sm med lrg	YES NO	
2 – 3AM			Sm med lrg	YES NO	
3 – 4AM			Sm med lrg	YES NO	
4 – 5AM			Sm med lrg	YES NO	
5 -6AM			Sm med lrg	YES NO	

I used _____pads today. I used _____ diapers today (write #)

Day 2

TIME	DRINKS What kind? How much?	TRIPS TO THE BATHROOM	Accidental Leaks How much? Circle one	Do you feel a strong urge to go? Circle one	What were you doing at the time? Sneezing, exercising, having sex, lifting,etc.
SAMPLE	Coffee 2 cups	✓✓ sm med lrg	Sm med lrg	YES NO	Running
6 – 7 AM			Sm med lrg	YES NO	
7 – 8AM			Sm med lrg	YES NO	
8 – 9AM			Sm med lrg	YES NO	
9 – 10AM			Sm med lrg	YES NO	
10 – 11AM			Sm med lrg	YES NO	
11 – 12PM			Sm med lrg	YES NO	
12 – PM			Sm med lrg	YES NO	
1 – 2PM			Sm med lrg	YES NO	
2 – 3PM			Sm med lrg	YES NO	
3 – 4PM			Sm med lrg	YES NO	
4 – 5PM			Sm med lrg	YES NO	
5 – 6PM			Sm med lrg	YES NO	
6 – 7PM			Sm med lrg	YES NO	

Day 2

TIME	DRINKS What kind? How much?	TRIPS TO THE BATHROOM	Accidental Leaks How much? Circle one	Do you feel a strong urge to go? Circle one	What were you doing at the time? Sneezing, exercising, having sex, lifting,etc.
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11 – 12AM			Sm med lrg	YES NO	
12 -1AM			Sm med lrg	YES NO	
1 -2AM			Sm med lrg	YES NO	
2 – 3AM			Sm med lrg	YES NO	
3 – 4AM			Sm med lrg	YES NO	
4 – 5AM			Sm med lrg	YES NO	
5 -6AM			Sm med lrg	YES NO	

I used _____pads today. I used _____ diapers today (write #)

Day 3

TIME	DRINKS What kind? How much?	TRIPS TO THE BATHROOM	Accidental Leaks How much? Circle one	Do you feel a strong urge to go? Circle one	What were you doing at the time? Sneezing, exercising, having sex, lifting,etc.
SAMPLE	Coffee 2 cups	✓✓ sm med lrg	Sm med lrg	YES NO	Running
6 – 7 AM			Sm med lrg	YES NO	
7 – 8AM			Sm med lrg	YES NO	
8 – 9AM			Sm med lrg	YES NO	
9 – 10AM			Sm med lrg	YES NO	
10 – 11AM			Sm med lrg	YES NO	
11 – 12PM			Sm med lrg	YES NO	
12 – PM			Sm med lrg	YES NO	
1 – 2PM			Sm med lrg	YES NO	
2 – 3PM			Sm med lrg	YES NO	
3 – 4PM			Sm med lrg	YES NO	
4 – 5PM			Sm med lrg	YES NO	
5 – 6PM			Sm med lrg	YES NO	
6 – 7PM			Sm med lrg	YES NO	

Day 3

TIME	DRINKS What kind? How much?	TRIPS TO THE BATHROOM	Accidental Leaks How much? Circle one	Do you feel a strong urge to go? Circle one	What were you doing at the time? Sneezing, exercising, having sex, lifting,etc.
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3 – 4AM			Sm med lrg	YES NO	
4 – 5AM			Sm med lrg	YES NO	
5 -6AM			Sm med lrg	YES NO	

Jefferson

833 Chestnut Street, Concourse
Philadelphia, PA 19107
T 215-955-5000
F 215-923-1089

Dear Patient,

Please be advised that effective January 1, 2012, Jefferson University Physicians (JUP) began charging a fee to patients that request a copy of their medical records. The fees below are the 2013 allowable amounts approved by the State of Pennsylvania. Please note that the fees are updated annually and are subject to change.

- $1.42 per page for the first 20 pages
- $1.05 per page for pages 21 – 60
- $0.42 per page for pages over 61

Actual postage amounts will also be charged for the mailing of records.

Just as a reminder, a completed JUP medical records release form must be on file.

If you have any questions, please contact Jefferson University Physicians Central Medical Records at 215-5038768.

Jefferson OB/GYN will be happy to assist you with the completion of the following forms:

- Disability Forms
- FMLA Forms
- Insurance Forms

Please be advised: You will be charged a $10.00 fee (per form) when submitting a form to our office for completion. This fee is not covered by your insurance and is separate from any co-pay or coinsurance. The fee must be paid when the form is submitted to be completed.

You have the option to pay with cash, check or credit/debit card.

Thank you in advance for your cooperation