Maine Medical
PARTNERS
Women's Health

Pelvic Medicine & Reconstructive Surgery
A Department of Maine Medical Center
100 Brickhill Ave., Suite 203, South Portland, ME 04106
Ph.: (207) 761-1502 Fax: (207) 774-2015

Dear Patient,

Welcome to our practice. Please fill out the enclosed paperwork **including the 24 hour voiding diary** and bring it with you to your appointment. Instructions for the voiding diary are included.

Team-based care is an important part of our practice. New patient visits are typically shared visits with the nurse practitioner and the urogynecologist.

Maine Medical Partners is part of a teaching institution and your care may also include a resident physician. Teaching resident physicians helps our team guide our future providers in the early stages of their careers. We may also have a medical student or student nurse practitioner working with us. Their role is more observational as a newer learner. Please let us know at the start of your visit if you would prefer to not be seen by the student learners.

We are looking forward to meeting you. Please call our office if you have any questions about your upcoming appointment.

Sincerely,

The urogynecology team at MMP Pelvic Medicine

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MMP Pelvic Medicine and Reconstructive Surgery
100 Brickhill Avenue, Suite 203, South Portland, ME, 04106
P: (207)-761-1502 ● Fax: (207)-774-2015

DIRECTIONS:

From I-95 North or South/Maine Turnpike: Take I-95 North or South to Exit 46. After the tollbooth, take a right onto Skyway Drive. Follow Skyway Drive to the light. At the light, take a right. Follow to the next intersection (get in the left turn lane). At the intersection, take a left onto Jetport Plaza. Follow Jetport Plaza to the stop sign. At the stop sign, take a right (this will be Westbrook St., however there is no street sign). Follow Westbrook Street for approximately 1/2 mile to Brickhill Avenue (on left). Turn left onto Brickhill Avenue, and follow the road up the hill until you reach 100 Brickhill Avenue (the large brick castle on your left).

From I-295 North: Take I-295 Southbound to Exit 3 (Westbrook St. /Airport). Take a right at the end of the exit ramp (Pape Chevrolet will be on your right) and proceed onto Westbrook Street. Follow Westbrook Street, bearing right at the stop light (Irving Gas Station will be on your left) to proceed up Westbrook Street. Follow Westbrook Street for approximately ¼ mile to Brickhill Avenue (on right). Turn right onto Brickhill Avenue and follow the road up the hill until you reach 100 Brickhill Avenue (the large brick castle on your left).

From Rte. 1 South/Scarborough: Follow Route 1 Northbound following signs for I-295. Take the exit labeled "Broadway." At the end of the "Broadway" exit ramp, bear right to proceed North on Broadway. Follow Broadway to the stop light. At the stop light, make a left turn onto Westbrook Street. Follow Westbrook Street past Pape Chevrolet to the next stop light (Irving Gas Station will be on your left). Bear right at the stop light to proceed up Westbrook Street approximately ¼ mile to Brickhill Avenue (on right). Turn right onto Brickhill Avenue and follow road up the hill until you reach 100 Brickhill Avenue (the large brick castle on your left).

From The West (Maine Mall): Follow Gorham Road Eastbound from the Maine Mall area past the Olive Garden Restaurant (on your right). At the next intersection, Gorham Road turns into Western Avenue (Young's Furniture and Sea Dog Brewery will be on your left). Go straight through the intersection and follow Western Avenue to the next light (get into the left turn lane). At the light, take a left onto Westbrook Street. Proceed up Westbrook Street approximately ¼ mile to Brickhill Avenue (on right). Turn right onto Brickhill Avenue and follow road up the hill until you reach 100 Brickhill Avenue (the large brick castle on your left).

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100 Brickhill Avenue, Suite 203, South Portland, ME 04106
P: 207-761-1502 Toll free: 1-800-584-3740 Fax: 207-774-2015

Pelvic Medicine Patient Information Questionnaire

Date: _____

Name: _____Date of birth: _____
Home Address: _____
Occupation: _____
Referring Physician: _____
_____

Other physicians/practitioners to whom a report should be sent:
_____
_____

Please give a brief history of your present problem or symptoms for which you were referred (Include the date of onset).

What previous **evaluations/tests** have you had for this problem?

What previous **treatments** have you had for this problem?

Urogynecologic Questions:

Urination:

Are you incontinent (involuntarily lose) your urine: Yes No
Does this happen with -physical activity: Yes No
-urgency? Yes No
-without awareness? Yes No
-constantly? Yes No
Are you concerned about your frequency of urination? Yes No
-Number of voids daytime? _____
-Number of voids nighttime? _____
Do you have painful urination? Yes No
Do you feel as though you completely empty your bladder? Yes No
Do you feel that your stream has a normal force and flow? Yes No
Do you have difficulty starting your stream? Yes No
Do you dribble urine after you stand from the toilet? Yes No
How many bladder (urinary tract) infections in the last year? _____
Do you do Kegel exercises? Yes No
How many ounces of caffeinated beverages do you drink in a day? _____
How many ounces of alcoholic beverages do you drink in a day? _____
How often and/or how long: _____
Do you take bladder control medications? Yes No
What? _____
Do you wear a pad? -What type? _____
-Number per day? _____

Bowel:

Are you incontinent of stool? Yes No
Do you have trouble controlling flatus (gas)? Yes No
Do you have blood in your stool? Yes No
Do you need to lean forward or press on your vaginal area to evacuate your stool? Yes No
How often do you have a bowel movement? _____
What is the consistency of your stool? Hard Soft Liquid
Do you use anything to assist your BMs? Yes No
What? _____

Vaginal/Uterine:

Do you feel anything protruding from your vagina? Yes No
If menopausal, have you had any vaginal bleeding? Yes No
Are you sexually active? Yes No
Is sexual activity uncomfortable: Yes No
Do you have an abnormal vaginal discharge: Yes No
If yes, describe: _____
_____

GYN HISTORY:

Last menstrual period: _____
If you are still having menses, do you have any problems: _____
_____
Do you or have you used hormone replacement therapy? If so, what and for how long?
_____
If applicable, what is your contraception? _____
Have you had abnormal paps? Explain: _____
Do you have a history of fibroids, endometriosis or other GYN conditions?
_____

OBSTETRICAL HISTORY:

Date of pregnancy:	Outcome (Miscarriage, cesarean, normal?)	Delivery problems?
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____

Medical Conditions:	**Medications to treat:**
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____
6._____	_____

Other Medications, prescriptions or over-the-counter, that you use regularly: _____
_____

Allergies: (medication or environmental):_____
_____
_____

Surgical Procedures:

Operation	Date	Hospital	Complications
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____

Hospitalizations other than for surgery:

Reason	Date	Hospital
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____

Home/Work:

Occupation: _____
Does your work involve heavy lifting or exertion? Yes No
Highest educational level: _____
Hobbies/interests: _____
Marital Status: _____

Do you exercise regularly? What type of exercise: _____
Do you or have you smoked cigarettes? _____ How many per day: _____
When did you quit? _____

Family History:

Do members of your family suffer from conditions related to their urinary or bowel function or to vaginal support? If so who and what was their problem? _____
_____

What other medical conditions run in your family: _____
_____

Review of Systems: (Please check any symptoms that you currently have)

General:

Headaches____ Fatigue____ Anxiety____ Depression____

Glaucoma____ Weight Loss ____ Weight gain____ Thyroid condition _____

Heart/Circulation:

Chest Pain____ Palpitations___ Leg edema (swelling) ____

Poor Circulation____ Mitral Valve Prolapse ____ Heart Murmur____ Varicose Veins ____

Lungs:

Asthma____ Shortness of breath____ Cough____

Gastrointestinal:

Indigestion____ Constipation____ Diarrhea____ Ulcers____

Hemorrhoids____ Nausea/Vomiting____ Cramps or Pain____

Kidney:

Kidney stones____ Blood in urine____

Muscular / Skeletal:

Arthritis____ Difficulty walking____ Difficulty with hands____

Weakness__ ____ Back Pain ____

Other:

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PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY
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Voiding Diary

In preparation for your visit to our office, please complete a voiding diary over a **24 hour period**. This information is very useful to us when we evaluate urinary symptoms including leakage and/or vaginal prolapse. It is important to **accurately measure** your fluid intake and output. Use a **standard measuring cup** or a **urinary hat** to measure your voids. You may obtain a hat at our office prior to your consult. This may avoid having a second visit to obtain this information. Please bring your completed 24 hour voiding diary with you to your appointment.

Instructions:

1. Begin recording in the morning upon awakening and continue for a full 24 hours.
2. Record separate lines for each urination or liquid consumed.
3. You may measure in milliliters (cc's) or ounces, but be consistent. **Please measure these volumes, do not estimate. Use a measuring cup to catch your urine.**
4. If you leak, estimate the volume as follows:
    1. is dampness or drops
    2. is a larger squirt or true wetness
    3. is a very large leak or most of your bladder content
5. If your leak is related to an uncontrolled urge, then mark Yes for urge and indicate what you were doing when this happened (standing up, running water, coming in the door etc.)
6. If your leak is not related to urge, then mark No for urge. You can also indicate the associated activity such as cough, sneeze, bend, etc.

Sample Diary:

Time	**Amount/Type of Intake**	**Amount Urinated**	**Leakage** 1 drops, 2 wet 3 soaked	**Urge Yes/No**	**Activity**
6 am		12 oz			
6:30 am	8 oz coffee				
10 am			2	No	Laughing
1:30 pm		6 oz	2	Yes	Running to the toilet

Name: _____DOB:_____

Time	**Amount/Type of Intake**	**Amount Urinated**	**Leakage** 1 drops, 2 wet 3 soaked	**Urge Yes/No**	**Activity**