Providence
Pelvic Health Center
www.womenspelvichealth.com
Robert Dodds MD & Meghan Griffin DO

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Farmington Hills, MI 48334
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Dear new patient,

We would like to thank you for choosing the Providence Pelvic Health Center for your care. This packet contains all the information necessary to make your visit smooth. Please complete to the best of your ability *prior to the visit.*

The following checklist will help you keep everything organized. Please check the box before each item when it is completed.

Complete the following *before* coming to office

- ☐ Bring your **Insurance Card** and **Identification** for check in
- ☐ If you have an HMO, obtain **Referral** from Primary Care Physician
- ☐ Obtain any necessary **medical records** (may fax or bring)
- ☐ Complete the **Patient Information Sheet** *(Below)*
- ☐ Complete the **Medical History Form** *(Page 2-3)*
- ☐ Complete the three symptom scales: **ICIQ-UI, PFDI-20, PFIQ-7** *(Page 4-6)*

This packet is designed to be completed on your computer before printing and signing. After completing, please either bring the forms to your visit or fax to (248) 538-5020. *NOTE: It will not go to our office unless you print it out and send it in.*

We look forward to meeting you!

Robert Dodds, MD
Meghan Griffin, DO

Patient Information Sheet

Name _____ _____

Birthdate _____

I have a current an **Advanced Directive?** ☐ Yes ☐ No

Referring Physician _____
Primary Care Physician _____
Preferred Pharmacy _____
pharmacy crossroads and phone number (____) ____-____

Providence Pelvic Health Center Intake Form

Name _____ Date _____

Medical History Form

In your own words, please write the nature of the medical problem for which you are being seen.

_____

_____

_____

For each of the symptoms listed below, please check "yes" if you have experienced ***in the last month***. If you have experienced a symptom not listed, please enter as "Other Symptom"

Constitutional

Fever / Chills	☐ Yes	☐ No
Unexpected weight change	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No

Eyes

Vision changes	☐ Yes	☐ No

Ear, Nose, Throat

Hearing loss	☐ Yes	☐ No
Sinus problems	☐ Yes	☐ No

Respiratory

Shortness of breath	☐ Yes	☐ No

Cardiovascular

Chest pain	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No

Breast

Lump or mass	☐ Yes	☐ No
Nipple discharge	☐ Yes	☐ No

Gastrointestinal

Nausea / vomiting	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Blood in stool	☐ Yes	☐ No
Bowel control issues	☐ Yes	☐ No

Genitourinary

Abnormal vaginal bleeding	☐ Yes	☐ No
Discharge	☐ Yes	☐ No
Odor	☐ Yes	☐ No
Itching	☐ Yes	☐ No
Menstrual problems	☐ Yes	☐ No
Sexual problems	☐ Yes	☐ No
Incontinence	☐ Yes	☐ No

Neurologic

Headache	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Seizures	☐ Yes	☐ No

Psychologic

Depression	☐ Yes	☐ No
Sleep disturbance	☐ Yes	☐ No

Other Symptoms not listed

Providence Pelvic Health Center Intake Form

Name _____ Date _____

Medical History Form - Continued

Medical Problems / Illnesses

Glaucoma	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Seasonal Allergies	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Arthritis/Back Problems	☐ Yes	☐ No
DVT	☐ Yes	☐ No	Osteoporosis/penia	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No	Seizures / Epilepsy	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No
Urinary Illness	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Anxiety / Depression	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No	Fibromyalgia	☐ Yes	☐ No
GERD / Ulcers	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Diverticulosis	☐ Yes	☐ No	STD/HIV/AIDS	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Sleep Disorder	☐ Yes	☐ No
Colitis	☐ Yes	☐ No	Other	☐ Yes	☐ No

Medications

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies

Medications	Reaction

Surgeries / Hospitalizations

_____
_____
_____
_____
_____
_____
_____

Social History/Habits

Alcohol	☐ Yes	☐ No
Tobacco	☐ Yes	☐ No
Illicit Drugs	☐ Yes	☐ No

Physician Notes

Obstetrics / Gynecologic History

Age of First Period	_____	Number of pregnancies	_____
Age of Last Period	_____	Number of miscarriages	_____
Cycle length	_____	Number of Termination	_____
Period length	_____	Ectopic pregnancies	_____
Abnormal pap	☐ Yes ☐ No	Number of living children	_____
Fibroids	☐ Yes ☐ No	Wt of Heaviest baby	_____
Infertility	☐ Yes ☐ No	☐ Bad tear with any delivery	

Current contraception: _____

Family History *(please list all chronic illnesses and cancers)*

Mother:	☐ Healthy	Other: _____
Father:	☐ Healthy	Other: _____
Grandparents:	☐ Healthy	Other: _____
Siblings:	☐ Healthy	Other: _____
Others:	☐ Healthy	Other: _____

Providence Pelvic Health Center Intake Form

Name _____ Date _____

International Consultation on Urinary Incontinence Questionnaire (ICIQ-UI SF)

Instructions: Think about how you have been, on average, **over the past four weeks**.

How often do you leak urine? *(Check one box)*

- Never ☐
- about once a week or less often ☐
- two or three times a week ☐
- about once a day ☐
- several times a day ☐
- all the time ☐

We would like to know how much urine you think leaks. How much urine do you usually leak (whether you wear protection or not)? *(Check one box)*

- none ☐
- a small amount ☐
- a moderate amount ☐
- a large amount ☐

Overall, how much does leaking urine interfere with your everyday life? *Please check 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 check all that apply to you)*

- never – urine does not leak ☐
- leaks before you can get to the toilet ☐
- leaks when you cough or sneeze ☐
- leaks when you are asleep ☐
- leaks when you are physically active/exercising ☐
- leaks when you have finished urinating and are dressed ☐
- leaks for no obvious reason ☐
- leaks all the time ☐

Providence Pelvic Health Center Intake Form

Name _____ Date _____

Pelvic Floor Distress Inventory (PFDI-20)

Instructions: Please answer all 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 these by putting an **X** in the appropriate box. While answering these questions, please consider your symptoms **over the last 3 months**.

			If Yes, how much does it bother you			
			Not at all	**Some-what**	**Mod-erately**	**Quite a bit**
1. Do you usually experience pressure in the lower abdomen?	Yes ☐	No ☐	☐	☐	☐	☐
2. Do you usually experience heaviness or dullness in the lower abdomen?	Yes ☐	No ☐	☐	☐	☐	☐
3. Do you usually have a bulge or something falling out that you can see or fell in the vaginal area?	Yes ☐	No ☐	☐	☐	☐	☐
4. Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?	Yes ☐	No ☐	☐	☐	☐	☐
5. Do you usually experience a feeling of incomplete bladder emptying?	Yes ☐	No ☐	☐	☐	☐	☐
6. Do you ever have to push up in the vaginal area with your fingers to start or complete urination?	Yes ☐	No ☐	☐	☐	☐	☐
7. Do you feel you need to strain too hard to have a bowel movement?	Yes ☐	No ☐	☐	☐	☐	☐
8. Do you feel you have not completely emptied your bowels at the end of a bowel movement?	Yes ☐	No ☐	☐	☐	☐	☐
9. Do you usually lose stool beyond your control if your stool is well formed?	Yes ☐	No ☐	☐	☐	☐	☐
10. Do you usually lose stool beyond your control if you stool is loose or liquid?	Yes ☐	No ☐	☐	☐	☐	☐
11. Do you usually lose gas from the rectum beyond your control?	Yes ☐	No ☐	☐	☐	☐	☐
12. Do you usually have pain when you pass your stool?	Yes ☐	No ☐	☐	☐	☐	☐
13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	Yes ☐	No ☐	☐	☐	☐	☐
14. Does part of your stool ever pass through the rectum and bulge outside during or after a bowel movement?	Yes ☐	No ☐	☐	☐	☐	☐
15. Do you usually experience frequent urination	Yes ☐	No ☐	☐	☐	☐	☐
16. Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?	Yes ☐	No ☐	☐	☐	☐	☐
17. Do you usually experience urine leakage related to laughing, coughing, or sneezing?	Yes ☐	No ☐	☐	☐	☐	☐
18. Do you usually experience small amounts of urine leakage (that is, drops)?	Yes ☐	No ☐	☐	☐	☐	☐
19. Do you usually experience difficulty emptying your bladder?	Yes ☐	No ☐	☐	☐	☐	☐
20. Do you usually experience *pain or discomfort* in the lower abdomen or genital region?	Yes ☐	No ☐	☐	☐	☐	☐

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Pelvic Floor Impact Questionnaire (PFIQ-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 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 related to the following→→→ Usually affect your ↓	**Bladder or Urine**	**Bowel or Rectum**	**Pelvis or Vagina**
1. Ability to do household chores (cooking, housecleaning, laundry)?	☐ 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

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Name _____ Date _____

Map and Directions

We have two office, one in Farmington Hills and one in Novi. They are both on the map below. We are only in Novi on Tuesday & Thursday afternoons and Friday mornings.

The two addresses are:

Farmington Hills *(West Entrance)*
30055 Northwestern Hwy, Suite 260
Farmington Hills, MI 48334

Novi
26850 Providence Parkway, Suite 420
Novi, MI 48374

Phone
Main Number (Both Offices): (248) 737-4600
Fax (248) 538-5020

Website
www.womenspelvichealth.com