



SOUTH COAST UROGYNECOLOGY WELCOMES YOU

...and thanks you for selecting us for your healthcare needs. We are dedicated to providing you with the best personalized healthcare and solutions. To help us do this, please fill out this form completely in ink. If you have any questions or need help, please ask us. We will be happy to help you. Complete this form prior to your visit if possible.

PERSONAL INFORMATION

Today's date _____ Social Security _____ Birthday _____
Name _____
Address _____
City/State/Zip _____
Age _____ Single Married Divorced Separated Widowed
Employer _____
Referred By _____ Primary Physician _____
Primary Physician Address _____
Primary Physician Phone # _____ Fax# _____

TELEPHONE INFORMATION

Home Phone _____ Work Phone _____ Ext. _____
E-Mail _____ Cell Phone _____

(We prefer and encourage e-mail communication for speed and efficiency)

When is it the best time to reach you? Mon Tues Wed Thurs Fri Sat Sun
Where do you prefer to receive calls? Home Work Cell Phone
Emergency Contact _____ Relationship _____
Home Phone _____ Work Phone _____ Cell Phone _____

RESPONSIBLE PARTY

Who is responsible for this account?
Name _____ Relationship to Patient _____
Address (if different from patient's) _____
City/State/Zip _____
Social Security # _____ Drivers License # _____ Birthdate _____
Employer _____ Occupation _____
Home Phone _____ Work Phone _____

INSURANCE INFORMATION

Primary Insurance		Secondary Insurance	
Name of Insurance	_____	Name of Insurance	_____
Subscriber #	_____	Subscriber #	_____
Group #	_____	Group #	_____
Name of Insured	_____	Name of Insured	_____
Relationship to Patient	_____	Relationship to Patient	_____
Insured's Birthdate	_____	Insured's Birthdate	_____
Soc. Sec. #	_____	Soc. Sec. #	_____

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT

PLEASE READ AND SIGN THE FOLLOWING:

I hereby assign all medical/surgical benefits to **South Coast Urogynecology, Inc. /Dr. Red Alinsod** and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of information necessary to secure the payment of benefits. I further agree that a photocopy of the agreement shall be as valid as the original.

SIGN HERE _____ DATE _____



Red Alinsod M.D.
Maggie Carpio PA-C

PAYMENT POLICY v2.1

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured, or not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your **coverage.**
2. **Co-payments and deductibles.** All co-payments must be paid before or at the time of service. All deductibles must be paid when the amount is known. This arrangement is part of your contract with your insurance company. This fee is your responsibility. We cannot guarantee the deductible amount since it varies among patients and their plans and what services have been accessed in the recent past. It is best to call your insurance company.
3. **Non-covered services.** Please be aware that some-and perhaps all-of the services you receive may be non-covered, considered investigational by some health plans, or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **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.
5. **Claims submission.** As a courtesy to you, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. It is your responsibility to ask your plan what is covered and what is not covered.
6. **Coverage.** 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. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During the 30 day period, our physician will only be able to treat you on an emergency basis.
8. **Missed appointments.** We may charge a \$25 fee for missed appointments not canceled within 24 hrs. These charges will be your responsibility.
9. **Bounced checks.** Please be advised there is a \$25 fee for any bounced or returned checks.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party _____ Date _____

Print Name _____



Red M. Alinsod, M.D.,
FACOG, ACGE

red@urogyn.org
Toll Free (877) 4-UROGYN
Main (949) 499-5311
Fax (949) 499-5312

Payment Policy for Aesthetic Surgery

Dr. Alinsod is the leading surgeons in his field of expertise and takes great pride providing quality and confidential care. Patients are exceptionally valued and provided extensive consultation time with both Dr. Alinsod and our patient liaison, enabling all questions and concerns to be addressed well in advance of scheduled surgery.

As you can imagine, surgical slots are at a premium. A great deal of thought has been given for evaluation, preparation, surgery time, and staffing needed for each procedure. In consideration for Dr. Alinsod's time, staff members, and fellow clients, we have an unwavering financial policy.

A 50% deposit is required at the time of scheduling surgery. This allows us to block the time needed for your surgery. The remaining balance is due one week prior to surgery. All fees must be received one week prior to surgery. A nonrefundable 25% of deposit will be retained for a cancelled surgery that is not rescheduled with Dr. Alinsod.

We accept cash, all major credit cards, and cashiers check. A 5% discount will be given for cash payments. Personal checks are not accepted. We provide several financing options and would be happy to discuss those with you.

Please note, additional surgical procedures cannot be added on the day of surgery unless payment in full has been received.

Sincerely,

Red M. Alinsod, M.D., FACOG, FACS, ACGE
Urogynecology & Reconstructive Pelvic Surgery

I agree and understand the SCU Payment Policy for Aesthetic Surgery.

Patient Signature

SCU Representative

Date





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To Our Patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you. This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. This will lower our billing costs. The combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. We will charge you only the portion of the insurer-determined payment not paid by the insurer. We will not do "balance billing," which is asking you to pay the difference between our normal fee and the insurer's normal payment. We will accept your insurer's allowable billing amount. This policy may not apply if you are a cash-paying patient.

If you do not have a credit card we will require a lawyer-style "retainer" of \$500 that is held in escrow and used to pay receivable amounts as they come due. Co-pays due at the time of the visit will, of course, still be due at the time of the visit. If you have any questions about this payment method, do not hesitate to ask us.

Our office will also have a "No-Show" fee of \$25 that is charged to your credit card if appointments are missed without a 24-hour notice. Our appointment slots are at a premium and we truly value the time we are able to spend with you.

Sincerely,

Red M. Alinsod, M.D., FACOG, FACS, ACGE

The Women's Center

31852 COAST HIGHWAY

SUITE 200

LAGUNA BEACH, CA 92651

www.urogyn.org



SOUTH COAST UROGYNECOLOGY
THE WOMEN'S CENTER
Laguna Institute for Aesthetic Vaginal Surgery
South Coast Laser Center

INITIAL HISTORY AND PHYSICAL

Date: _____

Appropriate sections to be completed by patient

Patient Name _____ Medical Record # _____

Age _____ Date of Birth _____

Pregnancies _____ Births _____ (Vaginal _____ Cesarean _____) Miscarriages _____ Abortions _____

Address: _____

Phone (Home) _____

Allergies: None

Phone (Work) _____

Yes _____

Phone (Cell) _____

Phone (Fax) _____

Email _____

Referring Physician: _____

Primary Care Physician: _____

How did you hear about us? _____

CHIEF COMPLAINT (Why you want to see the doctor today?)

AVS (Aesthetic/Vaginal Surgery) QUESTIONNAIRE

Skip this section. I have no problems with aesthetics or function of my vaginal area.

- _____ I want aesthetic vaginal surgery
- _____ My labia are larger than what I want
- _____ I do not like the way my labia looks
- _____ My labia rub, tug, and pull on my clothing
- _____ I am unable to wear the type of clothing I want
- _____ I have had unflattering comments about my genital region

- _____ I have had difficult births
- _____ My vagina feels too loose
- _____ I have decreased sensations
- _____ I feel pelvic heaviness
- _____ I rely on my appearance at work
- _____ Sex is uncomfortable and unpleasant at times

- I want Laser Hair or/and Vein reduction
- I want Laser/Fotofacial/Fraxel/Skin Tightening
- I want Laser Scar Reduction

- I want Botox
- I want Skin Fillers
- I want Scar/Stretch Marks Reduction

GYNECOLOGIC QUESTIONNAIRE

Do you have menstrual periods? ____ Yes ____ No (skip to PAP Questions below)
 Date of last menstrual period: _____
 If you have periods, are they: **regular / irregular, heavy / moderate / scant / painful?** Circle
 If irregular periods, for how long? ____ Months ____ Years
 If you have painful periods, does the pain occur **before or during or after** menses? Circle
 If painful periods, for how long? ____ Months ____ Years
 If you no longer have menstrual periods:
 Hysterectomy: Yes No Surgical removal of your ovaries: Yes No
 Do you take (or have you ever taken) hormone replacement? Yes No

When was your last PAP smear? _____ Normal / Abnormal. Circle
 Have you had treatments for abnormal PAPs? Yes No
 If yes, please explain: _____
 Are you having any abnormal vaginal discharge or discomfort? Yes No
 Do you have a feeling of vaginal fullness or pressure? Yes No
 Can you see or feel a swelling protruding from the vagina? Yes No
 Do you push the protrusion back to have a BM or empty your bladder? Yes No
 Are you sexually active? Yes No
 Are your partner(s): Men _____ Women _____ Both _____
 Do you have any sexuality concerns to discuss with us? Yes No
 If yes, please explain: _____

Birth Control: Do you have a need for birth control? Yes No
 Are you or your partner using any birth control now? Yes No
 If yes, what method? _____
 Are you satisfied with this method? Yes No
 Have you ever had a sexually transmitted disease? Yes No
 If yes, please explain: _____
 Do you have recurrent bladder infections? Yes No
 If yes, (1) Please explain: _____
 (2) Have you had kidney infection(s)? Yes No

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS (other current health problems):
 Skip this section. I am completely healthy without any conditions mentioned below.

Are you physically active? Yes No What type of exercise? _____
 Describe _____
 Do you now have or have you ever had:
 Neurologic (seizures, headaches, weakness, paralysis) problems? Yes No _____
 Psychiatric problems? Depression? Mania? Bipolar? Yes No _____
 Head/Ear/Eyes/Nose/Throat Problems? Yes No _____
 Thyroid problems? Yes No _____
 Cardiac (heart) problems? Palpitations? Chest Pain? Irregular Beat? Yes No _____
 Lung Problems? Asthma? Short of Breath? Yes No _____
 Breast Problem? Mass? Lumpiness? Discharge? Pain? Yes No _____
 Gastrointestinal (stomach) problems? Yes No _____
 Kidney or bladder disease? Stones? Infections? Yes No _____
 Liver problems? Yes No _____
 Hematologic (bleeding, anemia) bleeding problems? Yes No _____
 Diabetes (insulin dependent/oral medication) Yes No _____
 Musculoskeletal (bones, joints, muscles) problems? Yes No _____
 Circulation problems (varicose veins, thrombosis)? Yes No _____
 Cancer Yes No Type _____
 High Blood Pressure Yes No _____
 Other Problems _____

PAST SURGERIES OR HOSPITALIZATIONS

NONE

Please list with date:

FAMILY HISTORY (check illness which has occurred in any blood relative and write relationship to you):

____ Cancer (type and In whom) _____
____ Bleeding Disorder _____
____ Heart disease _____
____ Diabetes _____
____ Others _____

SOCIAL HISTORY

Marital status: S M W D
Occupation Not Working Working: What Occupation? _____
Tobacco use: Yes No Daily amount _____ Number of years _____
Alcohol use: Yes No Daily amount _____
Drug use Yes No Daily amount _____ Which Drugs? _____
Caffeine Use: Yes No Daily amount _____
Abuse Yes No Describe _____
Other: _____

MEDICATION HISTORY

NONE

Please list all current medications and dosages

ALLERGIES:

NONE: No known allergies (NKA)
 LIST ALLERGIES AND TYPE OF REACTION BELOW

REVIEW OF SYSEMS: LAST MAMOGRAM _____ Last LIPID PANEL _____
LAST COLONOSCOPY _____ Last FASTING SUGAR _____
LAST BONE SCAN _____

PUF QUESTIONNAIRE SCORE _____ Date _____

(Next section to be completed by doctor or nurse)

EXAMINATION: Date of Exam _____

Constitutional: Ht _____ Wt _____
Temp _____ BP _____ Pulse _____ Respiration _____

Appearance: **Normal** **Abnormal**
HEENT: _____
 ___ No thyromegaly
 ___ Throat clear

Heart: ___ No murmurs ___ Murmur
 ___ No heaves ___ Irregular Rhythm
 ___ No gallops
 ___ No irregularities

Lungs: ___ Clear ___ Congested Sounding
 ___ No Rales ___ Rales
 ___ No Wheeze ___ Wheeze

Breast/Chest: ___ No Mass ___ Fibrocystic Changes
 ___ No Discharge ___ Abnormal Discharge
 ___ Lymph Node Survey Normal ___ Abnormal Nodes

Abdomen: ___ Soft ___ Scars
 ___ No Masses ___ Mass Palpated
 ___ Non-Tender ___ Tender
 ___ Bowel Sounds Normal

Extremities: ___ No Cyanosis
 ___ No Clubbing
 ___ No Edema
 ___ No Malformations

Skin Lesions None _____
Lymph Nodes Normal _____
Hernias None _____

Other

Drawing:

UROGYNECOLOGIC EXAM: DATE of EXAM: _____

Introitus:	Normal	Virginal	Stenotic	Parous
Estrogenization	Normal	Atrophic		
Neurologic:	Clitoral Reflex: Normal	Decreased	Absent	
	Anal wink: Normal	Decreased	Absent	
Perineal Body:	Normal	Shortened	Bulging	
Vulvar/Perineal/Vaginal	Normal	Labial Enlargement		Labial Assymetry
Urethra: Appearance	Normal			
Urethral Hypermobility:	None	0, +, ++, +++		

Stress Test:	Upright	Negative	Positive	
	Standing	Negative	Positive	
Empty Bladder Stress Test		Negative	Positive	
Urethral Hypermobility		Negative	Positive	
Q-Tip Test:		Negative	Positive	_____ Degrees
Spontaneous Cough Strain Volume:		+, ++, +++		
BLADDER SCAN:	_____			

Vagina Pelvic Floor Musculature:		Tone: Good	Fair	Poor
Cystocele: (lateral / central / combined defect)		Stage 0, 1, 2, 3, 4		
Rectocele: (distal / proximal)		Stage 0, 1, 2, 3, 4		
Enterocoele:		Stage 0, 1, 2, 3, 4		
Vaginal cuff prolapse		Stage 0, 1, 2, 3, 4		
Vaginal Length: _____ normal	_____ shortened	_____ deep		
Vaginal Lesions:	_____			
Tenderness: (none / cuff / levator / bladder / introital/ uterus)				
Uterus Present _____	Absent _____			
Size (normal / enlarged / atrophic)		_____ week size		
Prolapse		Stage 0, 1, 2, 3, 4		
Describe	_____			
Adnexa Masses:	_____ None			
	Right _____			
	Left _____			
Andexal Tenderness	_____ None			
	Right _____			
	Left _____			
Rectal Exam:	_____ Normal			
	_____ No Mass	_____ Mass Palpated		
Rectal Tone:	_____ Normal	_____ Abnormal		
Hemorrhoids:	_____ None	_____ External	_____ Internal	
<input type="checkbox"/> Vaginal Laxity _____				
<input type="checkbox"/> Enlarged/Loose _____ Labia Minora	_____ Labia Majora			
<input type="checkbox"/> Assymetric Labia Minora				
<input type="checkbox"/> Excess Clitoral Hood				

Pelvic Organ Prolapse Assessment

Drawing

IMPRESSION:

Normal & Healthy Annual Examination
 Requests Contraception
 Peri-menopause/Menopause Requests Hormones
 SUI (Stress Incontinence)
 ISD (Intrinsic Sphincter Defficiency)
 DO (Detrussor Over Activity)
 OAB Wet Dry
 Overflow Incontinence
 Mixed Incontinence
 Cystocele Grade 0 1 2 3 4
 Rectocele Grade 0 1 2 3 4
 Enterocele Grade 0 1 2 3 4
 Uterine Prolapse Grade 0 1 2 3 4
 Vaginal Prolapse Grade 0 1 2 3 4
 Labial Enlargement/Asymmetry
 Vaginal Laxity
 IC
 CPP Endometriosis/Adenomyosis Adhesions Infection
 AUB Polyps Fibroids
 OTHER _____
 OTHER _____
 OTHER _____
 OTHER _____

PLAN & RECOMMENDATIONS:

PAP Lipids Hormone Panel CBC UA + C&S
 Mammo FBS Thyroid Panel Chem Panel Pregnancy Test
 GC/Chlam DNA Vag Culture Wet Mount Colposcopy
 Cystoscopy IC Test Bladder Study Hysteroscopy EMBx
 SLING/CYST ENT REP VAGINOPLASTY HTA FES/PEL FLO
 ANT REP OUTER SUSP PERINEOPLASTY EM RESECTION RENESSA
 POST REP MESH LABIA MAJ PLASTY EM ABLATION LAPAROSCOPY
 SSLs BIOLOGIC LABIA MIN PLASTY D&C LOA
 PIVS SITE SPECIF CLIT HOOD REDUC BLAD BOTOX FOL

Other: _____

CONSULTATIONS SCHEDULED:

Pre-Op With _____
 Anesthesia _____
 Other _____

FOLLOW UP _____ Days _____ Weeks _____ Months _____ Year/s

SIGNATURE _____

DATE _____

Dictated _____

SOUTH COAST UROGYNECOLOGY

Patient Name _____ Medical Record # _____

PRE-OP NOTE: The surgical case was discussed with the patient at length. The surgery/s is/are:

- | | |
|---|---|
| <input type="checkbox"/> Suburethral Sling, Cystoscopy | <input type="checkbox"/> Laparoscopy |
| <input type="checkbox"/> Anterior Repair, Paravaginal Repair | <input type="checkbox"/> Lysis of Adhesions |
| <input type="checkbox"/> Posterior Compartment Repair | <input type="checkbox"/> Fulguration of lesions |
| <input type="checkbox"/> Enterocele Repair | <input type="checkbox"/> Cystectomy |
| <input type="checkbox"/> Vaginal Vault Suspension | <input type="checkbox"/> LUNA |
| <input type="checkbox"/> SLS | <input type="checkbox"/> Ureteral Dissection |
| <input type="checkbox"/> PIVS | <input type="checkbox"/> Laparotomy |
|
 | |
| <input type="checkbox"/> TVH, Total Vaginal Hysterectomy | <input type="checkbox"/> Bilateral Salpingo-oophorectomy |
| <input type="checkbox"/> TAH, Total Abdominal Hysterectomy | <input type="checkbox"/> Unilateral Salpingo-oophorectomy |
| <input type="checkbox"/> LSH, Laparoscopic Supracervical Hys. | <input type="checkbox"/> Ovarian Cystectomy |
| <input type="checkbox"/> LAVH, Laparoscopically Assisted Vaginal Hysterectomy | |
| <input type="checkbox"/> LH, Laparoscopic Hysterectomy | |
|
 | |
| <input type="checkbox"/> Labiaplasty: <input type="checkbox"/> Minora <input type="checkbox"/> Majora | <input type="checkbox"/> Hysteroscopy |
| <input type="checkbox"/> Vaginoplasty | <input type="checkbox"/> Endometrial Resection |
| <input type="checkbox"/> Perineorrhaphy/Perineoplasty | <input type="checkbox"/> Endometrial Ablation/HTA |
| <input type="checkbox"/> Laser Resurfacing <input type="checkbox"/> Hair Reduction | <input type="checkbox"/> Polypectomy |
| <input type="checkbox"/> Hymenoplasty | <input type="checkbox"/> Myomectomy |
| <input type="checkbox"/> Clitoral Hood Reduction | <input type="checkbox"/> Septoplasty |
| <input type="checkbox"/> Abdominoplasty | <input type="checkbox"/> Dilatation and Curretage |
| <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> Cystoscopy with Bladder Botox |

Options of surgery were discussed such as expectant management, medical management, no surgery,

Risks of surgery were also discussed such as anesthesia, infection, bruising, bleeding, hemorrhage, transfusion, HIV, Hepatitis, anaphylaxis, aspiration, damage to internal organs such as bowel, bladder, urethra, ureter, major vessels, nerves, et al. Incisional hernias were discussed. The possibility of catheterization may be needed, an indwelling catheter may be used, and the possibility of urinary retention was also discussed and accepted. The possibility that the procedure may fail or a recurrence of symptoms may occur was also discussed at length. She understands further procedures or surgeries may be needed in the future for revision/repair/removal. No guarantees are implied or given to the patient regarding the safety and efficacy of the procedure. She has had a chance to ask all her questions to her satisfaction. The option to decline or delay surgery has been discussed at length. The patient wishes to proceed with surgery.

The possibility of infection/rejection/erosion/pain due to mesh or tissue were discussed if they are used. The type of implant (if needed) was discussed fully with the patient and she has agreed to its use in repairs. She understands that pain/dysparunia may occur with and without the use of mesh or tissue.

PATIENT SIGNATURE _____

PHYSICIAN SIGNATURE _____

DATE _____

REVIEWED _____

NO CHANGES _____

DATE _____

QUALITY OF LIFE & SYMPTOMS DISTRESS INVENTORY

NAME _____ DATE _____

Please answer each question by checking the best response between 0 (not at all) and 3 (greatly).

Incontinence impact questionnaire

Has urinary leakage and/or prolapse affected you:	0= not at all	1= slightly	2= moderately	3= greatly	
1. Ability to do household chores (cooking, housecleaning, laundry)?					PA
2. Physical recreation such as walking, swimming, or other exercise?					PA
3. Entertainment activities (movies, concerts, etc.)?					T
4. Ability to travel by car or bus more than 30 minutes from home?					T
5. Participation in social activities outside your home?					SR
6. Emotional health (nervousness, depression, etc.)?					EH
7. Feeling frustrated?					EH

Urogenital distress inventory

Do you experience, and, if so, how much are you bothered by:	0= not at all	1= slightly	2= moderately	3= greatly	
1. Frequent urination?					I
2. Urine leakage related to the feeling of urgency?					I
3. Urine leakage related to physical activity, coughing, or sneezing?					S
4. Small amounts of urine leakage (drops)?					S
5. Difficulty emptying your bladder?					OD
6. Pain or discomfort in the lower abdominal or genital area?					OD
7. A feeling of bulging or protrusion in the vaginal area?					OD
8. Bulging or protrusion you can see in the vaginal area?					OD

PA=physical activity; T=travel; SR=social/relationships; EH=emotional health;
OD=obstructive/discomfort symptoms; I=irritative symptoms; s=stress symptoms.

The Pelvic Pain and Urinary/Frequency (PUF) Patient Symptom Scale

Please circle the answer that best describes how you feel for each question.

	0	1	2	3	4	Symptom Score	Bother Score	
1. How many times do you go to the bathroom during the day?	3-6	7-10	11-14	15-19	20+			
2a. How many times do you go to the bathroom at night?	0	1	2	3	4+			
2b. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe				
3. Are you currently sexually active? Yes ___ No ___								
4a. If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always				
4b. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always				
5. Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes, or scrotum)?	Never	Occasionally	Usually	Always				
6. Do you have urgency after going to the bathroom?	Never	Occasionally	Usually	Always				
7a. If you have pain, is it usually...		Mild	Moderate	Severe				
7b. Does your pain bother you?	Never	Occasionally	Usually	Always				
8a. If you have urgency, is it usually...		Mild	Moderate	Severe				
8b. Does your urgency bother you?	Never	Occasionally	Usually	Always				
Symptom Score (1, 2a, 4a, 5, 6, 7a, 8a) =								
Bother Score (2b, 4b, 7b, 8b) =								
Total Score (Symptom Score + Bother Score) =								

PUF Patient Symptom Scale. © 2000 C. Lowell Parsons, M.D. Used with permission.

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date Completed: _____

Please mark below if there is a **personal or family history** of any of the following cancers. If yes, then indicate family relationship and **age at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	SIBLINGS/ CHILDREN	MOTHER'S SIDE	FATHER'S SIDE
<i>For example:</i> Colorectal cancer		<i>Brother 36 yrs</i>	<i>Aunt 44 yrs Cousin 58 yrs</i>	<i>Grandfather 65 yrs</i>

BREAST AND OVARIAN CANCER

Breast cancer				
Ovarian cancer				
Breast cancer in both breasts OR multiple primary breast cancers				
Male breast cancer				
Are you of Ashkenazi Jewish descent?				

COLON AND UTERINE CANCER

Uterine (endometrial) cancer				
Colorectal cancer				
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer				
10 or more cumulative colon polyps				

MELANOMA

Melanoma				
Pancreatic cancer				

OTHER CANCER

-------	--	--	--	--

FOR OFFICE USE ONLY

- | | |
|--|--|
| <input type="checkbox"/> Patient appropriate for further risk assessment and/or genetic testing <ul style="list-style-type: none"> <input type="checkbox"/> BRACAnalysis® – A test for Hereditary Breast and Ovarian Cancer <input type="checkbox"/> COLARIS® – A test for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer) <input type="checkbox"/> COLARIS AP® – A test for Adenomatous Polyposis Syndromes <input type="checkbox"/> MELARIS® – A test for Hereditary Melanoma | <input type="checkbox"/> Discussed hereditary cancer risk with patient
<input type="checkbox"/> Patient offered genetic testing
<input type="checkbox"/> ACCEPTED <input type="checkbox"/> DECLINED
<input type="checkbox"/> Follow up appointment scheduled
Date: _____ |
|--|--|