WELCOME TO THE UROGYNECOLOGY CENTER!

Your doctor has recommended that you be evaluated by the team at The Urogynecology Center. The Urogynecology Center was established in 1990. Our primary goal is caring for women with problems that include urinary and/or fecal incontinence, pelvic organ prolapse, or chronic pelvic and/or bladder pain. Since the establishment of this center, we have had a very high level of patient satisfaction due to the fact that we are a true subspecialty center devoted specifically to the management of patients with these types of problems. Our philosophy is to help you overcome your problem by performing a comprehensive evaluation beginning with a carefully performed history and physical examination. This is typically followed by some simple office testing utilizing state of the art equipment. The testing, together with the accurate assessment of your history and physical examination, allows us to more accurately diagnose and therefore treat your particular pelvic floor abnormality. After this evaluation, I will review with you the therapeutic options that would appropriately meet your needs. Whenever possible, a nonsurgical or minimally invasive approach will be offered. Your dignity and personal needs are always a major concern to us and will always be considered as we work together to address your specific problems.

The first step in your evaluation requires that you complete new patient paperwork, including a simple questionnaire and bladder diary (a record of how much you drink and how often you urinate). This is done prior to your first visit. I will then carefully review your history and these records so that I can fully understand the nuances of your problems and of your prior history related to your problems. Any and all records from previous care rendered will be reviewed; and therefore, it is always important to bring these records with you to your first visit. A comprehensive physical examination will then be done to determine the extent of any physical concerns, as well as an evaluation of pelvic muscular strength and function.

Your second office visit is designed to do some tests to evaluate your bladder function called Urodynamics (URO I). These tests involve filling your bladder with water to assess this bladder function and attempting to reproduce your particular symptom (incontinence, bladder pain, urgency, incomplete bladder emptying, etc). We will also want to determine how well you empty your bladder. Therefore, it is very important that when you arrive at the office your bladder is full. **We suggest that you drink 12 oz. of fluid 1½ hours prior to arrival** at the office and attempt to hold your urine until we ask you to void on our special commode. We have found that this is an adequate amount and you do not have to drink more than this. We also need you to be off your anticholinergic medications, such as Detrol, Ditropan, Oxytrol, Sanctura 3 days prior to the test and VESIcare and Enablex for 5 days prior to the test.

The last office visit (URO II) will involve a small scope designed for a woman's bladder. The scope will be used to visualize the inside of your bladder and urethra to further evaluate bladder anatomy and function. Therefore, it is very important that when you arrive at the office your bladder is full. We suggest that you drink at least 12 oz. of fluid 1½ hours prior to arrival at the office and attempt to hold your urine until we ask you to void on our special commode. I will then discuss with you (and your family when appropriate) the probable cause of your symptoms, and review with you the management plan that fits your needs.

As a courtesy to you, our patient…please be advised that you have been scheduled for outpatient diagnostic testing procedures that are performed in the physician's office. We have noted that many insurance plans require a deductible and/or coinsurance for these procedures. This means that you, the patient, may be responsible for some (or all) of the charges. Due to the expense of these procedures, it is strongly recommended that you review your plan benefits and if you are uncertain, you may contact your insurance company prior to your visit and find out what your plan benefits are. The Urogynecology Center's Staff cannot be responsible for providing this information for you, but if you have further questions, please feel free to contact our billing personnel. (Procedure codes used: 99204, 51729, 51784, 51741, 51797 and 52000). Medicare patients do not need to call Medicare for verification.

Enclosed you will find paperwork to be filled out and brought with you to your first visit. Please do not mail this paperwork. Also, remember to bring with you (or they can be faxed) any medical records that would assist me in understanding your past history of treatment for your symptoms. Please feel free to call with any questions.

I look forward to meeting you.

Charles (Chip) Butrick, M.D.
Director of The Urogynecology Center

Visit our new website at www.urogyncenter.com
Phone number: 913-307-0044
Fax Number: 913-227-0094

Charles W. Butrick, M.D., Director
12200 W 106th Street, Suite 130
Overland Park, KS 66215
Phone: (913) 307-0044 Fax: (913) 227-0094

Patient Questionnaire

IMPORTANT: Please complete this questionnaire carefully and bring it to your appointment.

Name: ________________________ Date of Birth: ____/____/____ Age: ____ Date of Visit: ____/____/____

Former Name/Nickname: ________________ Email: ________________ Employer: ________________

Address: ________________________ City, State, Zip: ________________________

Home Phone Number: ________________ Cell: ________________ Work: ________________

Marital Status (Please Circle One): Single Married Divorced Separated Widowed SS#: ________-______-________

Responsible Party: ________________________ Phone #: ________________________

Please circle any that are applicable: Retired Employed: Full-time Part-time Not Employed Student: Full-time Part-time

Pharmacy: Local: ________________________ Phone Number: ________________

Mail Order: ________________________ Phone Number: ________________

Who sent you to our office and/or how did you hear about us? ________________________

Physicians:

Primary Care Physician: ________________________ Phone Number: ________________

OB/GYN: ________________________ Phone Number: ________________

Cardiologist: ________________________ Phone Number: ________________

Other: ________________________ Phone Number: ________________

Insurance: Primary Insurance: ________________ Secondary Insurance: ________________

Subscriber: ________________ Subscriber: ________________

DOB: ________________ DOB: ________________

Employer: ________________ Employer: ________________

Assignment of Benefits

I hereby authorize The Urogynecology Center, LLC to file my insurance/Medicare/Medigap and assign benefits directly payable to The Urogynecology Center, LLC/Charles Butrick, M. D. I authorize The Urogynecology Center, LLC to release any medical information that may be necessary for my medical care for the processing of financial benefits. I further agree that a photocopy of the agreement shall be as valid as the original.

Patient / Guardian Signature: ________________________________ Date: ________________

Financial and Payment Policies

Thank you for choosing us as your healthcare 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 these financial and payment policies. Please read it, ask us any questions you may have, 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 are contracted with, payment in full is expected at each visit. If you are insured by a plan we are contracted 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.**
2. **Co-payments and deductibles.** All co-payments must be paid 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 insurance plans and what services have been accessed in the recent past. It is best to for you to call your insurance company. We accept cash, check, MasterCard and Visa.
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 current valid insurance card 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 claim 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 from the date of service, the balance may automatically be billed to you.
7. **Nonpayment.** If you account is over 90 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be considered as bringing your account up to date unless otherwise negotiated in advance. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by 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 cancelled within 24 hours. These charges will be your responsibility.
9. **Returned checks.** Please be advised there is a $25 fee for any returned check.

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 financial and payment policies. Please let us know if you have any questions or concerns.

I have read and understand the financial and payment policies and agree to abide by their guidelines.

Signature of patient or responsible party ____ Date ____________________
Print Name ____

Patient Name:____ **D.O.B.**______________________

CHIEF COMPLAINT

Please briefly describe the reason(s) that you are being seen in our office: ____
____

For how long have you experienced each problem? ____

PAST MEDICAL HISTORY

Have you ever had any of the following problems? Please circle Yes or No and if yes, please explain:

		EXPLAIN:
Yes / No	Bleeding problems (blood clots, anemia, past transfusions)	______________________
Yes / No	Cancer	______________________
Yes / No	Diabetes	______________________
Yes / No	Eye Disorder (glaucoma, chronic dryness)	______________________
Yes / No	Neurological problems (seizures, migraines, stroke, fibromyalgia)	______________________
Yes / No	Gastrointestinal disorder (ulcers, reflux, IBS)	______________________
Yes / No	Heart problems (irregular heart beat, murmur)	______________________
Yes / No	Hernia	______________________
Yes / No	High Blood Pressure	______________________
Yes / No	Kidney problems (stones, infection, decreased function)	______________________
Yes / No	Liver Problems (hepatitis, gallbladder disease)	______________________
Yes / No	Musculoskeletal problems (osteoarthritis, loose joints, fibromyalgia)	______________________
Yes / No	Psychiatric problems (depression, anxiety, bipolar disorder)	______________________
Yes / No	Respiratory problems (asthma, COPD, emphysema, sleep apnea)	______________________
Yes / No	Skin disorder (herpes, psoriasis)	______________________
Yes / No	Spine injury	______________________
Yes / No	Thyroid disease	______________________
Yes / No	Other:	______________________

SURGICAL HISTORY

☐ **I have never had any type of surgery – skip this section.**

List ALL surgeries with the date, if possible. Include abdominal and plastic surgeries, also include date:

____
____
____
____

ALLERGIES

Allergic To:	Reaction	Allergic To:	Reaction
______________	______________	______________	______________
______________	______________	______________	______________
______________	______________	______________	______________
______________	______________	______________	______________

MEDICATIONS

☐ **I do not take any medications – skip this section.**

List all of the medications that you currently take, including over-the-counter medications and herbal supplements. List the dosage and how often you take it.

______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Patient Name:____ **D.O.B.** ____________________

OBSTETRICAL HISTORY

☐ I have never been pregnant – skip this section.

Number of pregnancies: _____ **Miscarriages:** _____ **Abortions:** _____ **Living Children:** _____

Date of Childs Birth:	Birth Weight:	Type of Delivery:		
____________	________	☐ Vaginal	☐ Forceps / Vacuum	☐ C-section
____________	________	☐ Vaginal	☐ Forceps / Vacuum	☐ C-section
____________	________	☐ Vaginal	☐ Forceps / Vacuum	☐ C-section
____________	________	☐ Vaginal	☐ Forceps / Vacuum	☐ C-section
____________	________	☐ Vaginal	☐ Forceps / Vacuum	☐ C-section
____________	________	☐ Vaginal	☐ Forceps / Vacuum	☐ C-section
____________	________	☐ Vaginal	☐ Forceps / Vacuum	☐ C-section

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Living situation ☐ Alone ☐ Family ☐ Skilled nursing facility/nursing home ☐ Other__________

Sexually Active ☐ Yes ☐ No

Tobacco use: ☐ Yes ☐ No **Daily amount:** ________________ **# of years:** ______________

Alcohol use: ☐ Yes ☐ No **Amount:** ____

Street drug use: ☐ Yes ☐ No **Type/amount:** ____________________________________

Caffeine use: ☐ Yes ☐ No **Type/amount:** ____________________________________

Exercise: ☐ Yes ☐ No **Describe:** ____

Sexual Abuse: ☐ Yes ☐ No: **Describe:** ____

FAMILY HISTORY

Please circle Yes or No and complete the relationship portion:

		RELATIONSHIP
YES / NO	Bleeding disorder	______________________________
YES / NO	Cancer (list type)	______________________________
YES / NO	Diabetes (Type)	______________________________
YES / NO	Heart disease	______________________________
YES / NO	Hernia or vaginal prolapse	______________________________
YES / NO	Urinary problems	______________________________
YES / NO	Other	______________________________

Patient Name: ____ D.O.B: ___________________

Review of Systems

Check any conditions you've had in the past six months:

Constitutional
- ☐ Recent weight change
- ☐ Fever
- ☐ Weakness
- ☐ Other:_______________

HEENT
- ☐ Visual problems
- ☐ Hearing Problems
- ☐ Dry Mouth
- ☐ Other:___________

Cardiovascular
- ☐ Chest Pain
- ☐ Varicose veins
- ☐ Blood clots
- ☐ High blood pressure

Respiratory
- ☐ Chronic cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Other:___________

Gastrointestinal
- ☐ Heartburn/Indigestion
- ☐ Nausea/Vomitiing
- ☐ Hemorrhoids
- ☐ Abdominal Pain
- ☐ Constipation/Diarrhea
- ☐ Fecal Incontinence
- ☐ Other:________________

Musculoskeletal
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Limited mobility
- ☐ Other:____________

Neurological
- ☐ Paralysis
- ☐ Numbness
- ☐ Tingling
- ☐ Dizzy Spells
- ☐ Headaches
- ☐ Insomnia
- ☐ Memory loss

Skin
- ☐ Rashes
- ☐ Sores
- ☐ Lumps
- ☐ Persistent itch/hives
- ☐ Other:___________

Endocrine
- ☐ Hot flashes
- ☐ Excessive thirst
- ☐ Fatigue
- ☐ Other:____________

Hematological
- ☐ Easy bruising
- ☐ DVT
- ☐ Blood Clotting
- ☐ Other

Immunologic
- ☐ Swollen Lymph nodes
- ☐ Anxiety
- ☐ Other:_____________

Psychiatric
- ☐ Depression
- ☐ Other:___________

Gynecological
- ☐ Abnormal bleeding
- ☐ Painful periods
- ☐ Painful intercourse
- ☐ PMS
- ☐ Infertility
- ☐ Abnormal vaginal discharge
- ☐ Frequent yeast infections

Urinary
- ☐ Recurrent UTI's
- ☐ Urinary frequency
- ☐ Urinary urgency
- ☐ Urinary Incontinence (Leakage)

Breasts
- ☐ Pain in breast
- ☐ Nipple discharge
- ☐ Breast lump(s)

Eyes
- ☐ Blurred vision
- ☐ Glaucoma

☐ YES ☐ NO **Do you feel satisfied with your life?**
Comments: ____

☐ YES ☐ NO **Do you feel severely depressed?**
Comments: ____

☐ YES ☐ NO **Have you considered suicide in the last 12 months?**
Comments: ____

☐ YES ☐ NO **Have you ever had: AIDS, Hepatitis or other viral condition(s)?**
Comments: ____

Patient Name: ____ **D.O.B.** ______________________

UROGYNECOLOGIC QUESTIONNAIRE

1. I urinate every ____________ hours during the day.
2. At night, I get up __________ times to urinate

YES / NO Do you lose urine with laughing, sneezing or exertion?

What amount of urine do you lose? Small Large
In what position do you lose urine? Sitting Standing Lying down

YES / NO Do you lose urine with a strong sense of urgency?

YES / NO Does the sound , sight, or feel of running water make you lose urine?

YES / NO Do you lose urine without any warning (without activity or urgency)?

YES / NO Do you wear a pad? If so, how many pads per 24 hours? _______________

YES / NO Is it difficult to get your urine stream started?

YES / NO Does your urine stream seem slow or weak

YES / NO Do you feel that you empty your bladder completely when you urinate?

YES / NO Do you have pain associated with urination?

YES / NO Do you have frequent bladder infections?

YES / NO Did you have childhood problems with your bladder (bed wetting, etc.)?

YES / NO Do you feel as if your pelvic organs are "falling down"?

YES / NO Do you feel a bulge at the opening of your vagina?

BOWEL FUNCTION QUIESTIONNAIRE

I move my bowels ________ times per day or _______ times per week.

YES / NO Do you have difficulty emptying your rectum?

What is the consistency of your stool when this happens? Liquid Soft Normal Hard

YES / NO Does it help to press on the inside or outside of the vagina?

YES / NO Do you lose control of stool?

What is the consistency of your stool when this happens? Liquid Soft Normal Hard

YES / NO Do you have problems controlling gas?

YES / NO Do you have alternating constipation and diarrhea?

YES / NO Do you have pain with bowel movements?

YES / NO Do you ever see blood in your stools?

YES / NO Did you have childhood problems with your bowels?

Patient Name: ______________________________ **D.O.B:** ______________

COSMETIC GYNECOLOGY QUESTIONNAIRE

YES / NO I am self-conscious about the appearance of my vulva/vagina.

YES / NO I am unhappy with the way vagina looks (i.e. gaping).

YES / NO I am unhappy with the way my labia look (irregular, dark, long)

YES / NO My labia rubs or pulls on my clothing or during sex.

YES / NO I am unable to wear the type of clothing that I want to.

YES / NO My vagina feels loose during sex.

YES / NO I have decreased sensation during sex.

YES / NO I wish to enhance my pleasure with sex.

YES / NO I want cosmetic vaginal surgery.

SEXUAL FUNCTION QUESTIONNAIRE

Sexual orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other

YES / NO I have low desire to participate in sexual activity.
YES / NO I am unable to reach an orgasm.
YES / NO I have significant difficulty reaching orgasm.
YES / NO I have a difficult time becoming aroused during sexual activity.
YES / NO I do not become sufficiently lubricated with sexual activity.
YES / NO I experience pain with vaginal penetration

DERMAL AESTHETIC QUESTIONNAIRE

YES / NO Do you have any concerns with the appearance of your skin?

YES / NO Do you have any issues with Spider veins/varicose veins?

YES / NO Do you have any Anti aging skin care concerns?

YES / NO Do you want to learn more about Skin care products?

YES / NO Do you have any issues with wrinkles or fine lines?

YES / NO Do you have any issues with Sun spots/Age spots?

YES / NO Do you have any concerns with Aging/dull looking skin?

YES / NO Do you have any issues with Large pores/Skin texture?

YES / NO Do you have any concern with Flushing of the skin/Redness?

YES / NO Do you have any interest in Laser Hair Removal?

If yes, what areas: ______________________________

Additional Comments/Notes: ______________________________

____

____

____

____

____

PLEASE COMPLETE THIS DIARY AND HAVE READY FOR YOUR FIRST APPOINTMENT.

Bladder Diary

To help us evaluate your problem and bladder function we ask that you complete this diary. We may also have you complete a diary to evaluate your response to therapy. We need you to keep track of the amount of liquids you drink and the amount you void in a 24 hour period before your first appointment. Please complete this form even if you do not feel that your appointment is for a bladder problem. **Many times other conditions can be identified with the bladder diary.**

It is **very important that you complete** the diary **before** your first appointment. If you have any questions please call the office and speak with one of the nurses. **913-307-0044 ext 2**.

INSTRUCTIONS:

1) Fill out one sheet for each day. Please record for a full 24 hour period.
2) Record the time you drink and the amount and the type of fluid. Please use ounces or cc's (ml is same as cc) measurements,
3) Record the time and amount of urine voided, catheterized, or accidents. If accidents, please estimate amount by small, moderate, or large amount of loss.
   (We do not need the urine specimen, just the amounts you measure.)
4) A 24 hour diary is all that is needed unless you have been instructed to do one for a longer period of time.

You can pick up a measuring "hat" to place in the toilet for catching the urine to measure free of charge from our office, or you can get a similar device from most pharmacies for approximately $2.00. A measuring cup works just as well as the measuring "hat" if you are not able to get one from the pharmacy or are unable to make it by our office before you first appointment. You can also use any type of cup or bowl that you have at home to catch the urine to measure.

5) Below is an example of a diary. A blank diary is provided for you to use. If you need additional spaces, please make a copy.

Time	Amount of Fluid Intake & Type	Volume of Urine Voided	Symptoms or reason for accident(e.g. pain, urge too strong, cough, exercise)	Small Accident	Moderate Accident	Large Accident
7:10 am		8 oz	Urge too strong		√	
7:30 am	12 oz of coffee					
7:49 am		12 oz	No accident			
8:30 am	8 oz of coffee				√	
8:42 am		3 oz	Did have burning after urinating.		√	
10:30 am		8 oz	Cough	√		
10:35 am	10 oz Tea					
11:30 am	12 oz Diet Coke					

BLADDER DIARY

NAME: ______________________________ **DATE:** ______________________

TIME	AMOUNT OF FLUID INTAKE AND TYPE	VOLUME OF URINE VOIDED	SYMPTOMS OR REASON FOR ACCIDENT (e.g. PAIN, URGE TOO STRONG, COUGH)	SMALL ACCIDENT	MODERATE ACCIDENT	LARGE ACCIDENT