Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

PACIFIC UROLOGY

100 N. WIGET LANE, SUITE 290, WALNUT CREEK, CA 94598 - (925) 937-7740, FAX (925) 933-9868
2222 EAST STREET, SUITE 250, CONCORD, CA 94520 - (925) 609-7220, FAX (925) 689-3298
5201 NORRIS CANYON RD, SUITE 140, SAN RAMON, CA 94583 - (925) 830-1140, FAX (925) 275-0454

PATIENT INFORMATION

Please Print Clearly & Fill Out Completely

Last Name	First Name	Middle Initial
Date of Birth	Age	Social Security Number
Address		
City	State / Zip	Email
Home Phone ( ) -	Cell Phone ( ) -	Work Phone ( ) -

PHYSICIAN INFORMATION

Physician Who Referred You To Our Office	Diagnosis or Reason for Referral
Primary Care Physician	Physician You Are Seeing At Our Office

PRIMARY INSURANCE COVERAGE

Insurance Company Name	Insurance Care is in the Name of? ❑ Self ❑ Spouse ❑ Other _____

Complete the following information for the person whose name appears on the Insurance Card:

Name	Date of Birth	Social Security Number
Group #	Plan Name	
Policy ID #	Medical Group Name	Co-Pay $

Does your insurance require a referral to see a Specialist? ❑ NO ❑ YES (If YES, please give referral slip to Receptionist)

SECONDARY INSURANCE COVERAGE

Insurance Company Name	Insurance Care is in the name of? ❑ Self ❑ Spouse ❑ Other _____

Complete the following information for the person whose name appears on the insurance card:

Name	Date of Birth	Social Security Number
Group #	Plan Name	
Policy ID #	Medical Group Name	Co-Pay $

Does your insurance require a referral to see a Specialist? ❑ NO ❑ YES (If YES, please give referral slip to Receptionist)

EMERGENCY CONTACT

Name	Relationship	Phone

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize my physician and Pacific Urology (PU) to submit insurance claims on my behalf. I authorize my insurance company or its carriers to disclose any information requested by my physicians regarding claims for medical services they provide me. I authorize John Muir Medical Center, San Ramon Valley Medical Center or any other hospital where I may be a patient to release information requested by PU. I authorize PU to release information to physicians referred by PU. I authorize payments of assigned medical benefits to be paid directly to my physician and PU. I am responsible for deductibles, coinsurance, and non-covered items. I agree to pay any co-payments required by my insurance plan at the time of service. I understand that Pacific Urology does not bill tertiary insurances, other than Medicare or MediCal.

*** **SIGNATURE**: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

PATIENT DEMOGRAPHICS

RACE / ETHNICITY

- ❑ Decline to Answer
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Hispanic or Latino
- ❑ Native Hawaiian / Pacific Islander
- ❑ White / Caucasian

GENDER / STATUS

GENDER: ❑ Male ❑ Female

MARITAL STATUS:

- ❑ Decline to Answer
- ❑ Single
- ❑ Divorced
- ❑ Married
- ❑ Domestic Partner
- ❑ Widow
- ❑ Other

PREFERRED LANGUAGE

- ❑ Decline to Answer
- ❑ English
- ❑ Spanish
- ❑ French
- ❑ Punjabi
- ❑ Hindi
- ❑ Sign Language - Deaf
- ❑ Vietnamese
- ❑ Chinese
- ❑ Russian
- ❑ Tagalog
- ❑ Italian
- ❑ Other

CONTACT PREFERENCE

Check <u>One</u>:
❑ **HOME** ❑ **CELL** ❑ **WORK** ❑ **MAIL**

OCCUPATION

Current or Previous:

PRACTICE SELECTION

What factors helped you choose our practice for your medical care? *(Check all that apply)*

- ❑ Referred by Physician
- ❑ Hospitalist Referral
- ❑ Convenient Location
- ❑ Comprehensive Services
- ❑ Reputation of Practice
- ❑ Reputation of Physicians
- ❑ Family/Friend Recommended
- ❑ Website
- ❑ Internet Search
- ❑ News Story
- ❑ Articles in Papers
- ❑ Newspaper Ad
- ❑ Community Event
- ❑ Social Media
- ❑ Speaker Program
- ❑ Other

May we keep you informed of PU news & events via confidential Email? ❑ Yes ❑ No Email:

PATIENT INFORMATION AUTHORIZATION – HIPAA PRIVACY

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of Protected Health Information (PHI). Completion of this form tells us your preferences with regard to telephone messages and whom you give authorization for our office to speak with on your behalf. Further authorization may be needed under more specific circumstances.

CONTACT PREFERENCE *(Check <u>ONE</u>):* ❑ **HOME** ❑ **CELL** ❑ **WORK** ❑ **MAIL**

Below…Please check <u>ALL</u> that apply:

HOME PHONE	CELL PHONE	WORK PHONE	MAIL / EMAIL / FAX
❑ OK to leave detailed message*	❑ OK to leave detailed message*	❑ OK to leave detailed message*	Billing Statements & Correspondence will be mailed to your Home unless you provide alternate address:
❑ Leave message with call-back number only	❑ Leave message with call-back number only	❑ Leave message with call-back number only	❑ OK to contact you via Email **EMAIL:**
HOME # ( ) -	**CELL #** ( ) -	**WORK #** ( ) -	**HOME FAX #** ( ) - **WORK FAX #** ( ) -

** Either with any individual, other than yourself, whom answers the phone or on an answering machine.*

OTHER AUTHORIZED INDIVIDUALS

Other individuals I authorize to take messages or receive my Protected Health Information are:

NAME *(List <u>all</u> that apply)*	RELATIONSHIP TO YOU	CONTACT INFO
	Spouse / Significant Other	Phone: ( ) -
		Phone: ( ) -
		Phone: ( ) -
		Phone: ( ) -

I request the following <u>restrictions</u> to the use or disclosure of my health information:

My signature below authorizes Pacific Urology (PU) to use my Protected Health Information per my instructions above and acknowledges that I have received PU's Notice of Privacy Practices & I consent to the use and disclosure of my health information for treatment, payment or healthcare operations.

*** **SIGNATURE**: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient
PU Witness Name / Signature	Date

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

FINANCIAL POLICIES

CO-PAYMENT, DEDUCTIBLE & CO-INSURANCE COLLECTION POLICY

We are required by law, and your health plan, to collect co-payments at the time of service. Co-payments are required each time you are seen by the physician or nurse practitioner. This co-payment is for the limited office visit charge that covers the medical management that the physician provides in overseeing your treatment. **This policy is established by your health plan** and is explained in your benefits handbook and is usually printed on your insurance card.

It is our policy to collect coinsurance and deductibles at the time of service. Prior to any scheduled hospital procedure, any coinsurance and deductible will be collected at the time of the pre-operative visit. If you have any questions or concerns about your insurance coverage, please call your insurance carrier directly.

It is the patient or guardian's responsibility to determine if the doctor you are seeing is a contracted provider with your insurance. If required insurance cards, co-pays and/or authorizations are not provided at the time of your service, your appointment may be rescheduled.

INSURANCE REIMBURSEMENT & BILLING POLICIES

BILLING STATEMENT: We are happy to bill your insurance as a courtesy to you. Each month you will receive a statement from us describing your current balance and any charges incurred during the statement month. You can submit this bill yourself, along with the appropriate forms, to your insurance carrier. Or, as many of our patients prefer, we will bill your primary and secondary insurance carrier for you. Pacific Urology does not bill tertiary insurance coverage other than Medicare or MediCal. For us to do so, you must sign the "*Release of Information & Assignment of Benefits*" statement on the first page of this packet. We will bill your insurance a maximum of three (3) times, then the responsibility for handling issues with insurance reimbursement rests with you. You are ultimately responsible for payment of your bill.

When you receive our monthly statement, payment is expected within thirty (30) days. Payments are considered delinquent after sixty (60) days. If Pacific Urology or its physicians are not contracted with your insurance carrier, you are considered a "self-pay" patient and payment is due in full at the time of service.

ATTORNEY FEES AND COLLECTION COSTS: If any legal action is necessary to enforce or interpret the terms of these billing policies, the prevailing party shall be entitled to reasonable attorneys' fees, costs and necessary disbursements in addition to any other relief to which that party may be entitled. You agree by your signature below to pay all collection costs, including attorneys' fees on all delinquent payments.

SUSPENSION OF CARE (EXCEPT EMERGENCY CARE): If no payment is received after ninety (90) days, we may be forced to suspend all but emergency care until a payment is received. Please discuss all billing issues directly with our billing department.

ADMINISTRATIVE FEES

Due to the high volume of requests we receive, we charge administrative fees for copying of all or part of a medical record, completion of disability forms, printouts of your billing statements, and other such administrative requests. The current fee schedule (which is subject to change) is:

Printing of Medical Records Fee:	$ 25.00 (extensive records will be charged at a higher rate)
Established Patient No-Show:	$ 25.00
New Patient No-Show:	$ 50.00
Reschedule of Surgery:	$100.00
Disability Forms:	$ 25.00
Pre-Authorization of Medications:	$ 25.00
Returned Check Charge:	$ 25.00

My signature below indicates that I have read, understood and agreed to the Financial Policies of Pacific Urology

Signature: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient

A copy of this page will be provided to you at your request *Revised 07/15/2013*

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

Reason for your visit today? Be precise.

Physician that referred you for care at Pacific Urology: _____

PAST MEDICAL HISTORY

Do you have or have you had any of the following conditions?	YES	NO	Type / Year Diagnosed
Cancer (kidney, bladder)	❑	❑	
Heart (chest pain, heart attack, murmur)	❑	❑	
Have you had an EKG?	❑	❑	When/Where?
High Blood Pressure	❑	❑	
Pacemaker	❑	❑	
Blood or clotting problems	❑	❑	
Breast- cancer	❑	❑	
Stomach/Liver (reflux, bleeding, hepatitis, etc)	❑	❑	
Bowels (change in bowel habits, constipation, diarrhea)	❑	❑	
Glands (Diabetes, thyroid, gout)	❑	❑	
Gynecologic System (female organs)	❑	❑	
Musculoskeletal (arthritis, disc disease)	❑	❑	
Eyes/Ears/Nose/Throat	❑	❑	
Stroke	❑	❑	
Lungs (Asthma, Emphysema, Pneumonia, shortness of breath, TB)	❑	❑	
Bladder Disease	❑	❑	
Brain/Nervous System (seizure, "blackout spells")	❑	❑	
Mental Illness (Nervous condition/Depression)	❑	❑	
Skin (rash, psoriasis, hives)	❑	❑	
Constitutional (unexplained weight loss, fevers, chills, night sweats)	❑	❑	
Any other illnesses?	❑	❑	
Have you had any accidents/injuries within the last 24 months?	❑	❑	
Have you ever received the Shingles Vaccine?	❑	❑	

PAST SURGICAL HISTORY

Type of Operation	Surgeon	Date(s)
Do you have any artificial joints and/or heart valves? ❑ Yes ❑ No	If yes, give which & date:	
Have you ever had a blood transfusion? ❑ Yes ❑ No	If yes, when?	

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

Names of ***ALL*** Physicians			
Name	**Phone**	**Address**	**Specialty**

GYNECOLOGICAL HISTORY	**YES**	**NO**	
Is there any chance you could be pregnant?	❑	❑	
Have you ever taken birth control pills?	❑	❑	
Have you ever taken hormone replacement therapy?	❑	❑	If yes, when:
Do you have a family history of breast cancer?	❑	❑	
Have you had a hysterectomy?	❑	❑	If yes, What type? ❑ Vaginal or ❑ Abdominal
			If yes, Reason:
If yes, were tubes and ovaries removed?	❑	❑	
Are you sexually active?	❑	❑	
Do you frequently have pain with intercourse?	❑	❑	

Number of pregnancies		Number of live births		Number of Cesarean Sections	
Age at first pregnancy		Did you breastfeed?		Date of last mammogram	
Date of last pap smear		Onset of menstruation (age)		Age at menopause	
Date of last menstrual period					

FAMILY HISTORY			
RELATION	**AGE(S)**	**STATE OF HEALTH**	**IF DECEASED, CAUSE/AGE OF DEATH**
Mother			
Father			
Siblings			
Spouse			
Children			
Are you of Ashkenazi Jewish descent?	**YES** ❑	**NO** ❑	

Please list any diseases that run in your family, such as cancer, kidney stones, diabetes, etc.

Disease	Family member

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

REVIEW OF SYSTEMS

Have you experienced any of these problems during the past month?

	YES	NO		YES	NO
Weight loss	❑	❑	Chest Pain/Palpitations	❑	❑
Fevers	❑	❑	Mood changes or Depression	❑	❑
Chills	❑	❑	Trouble sleeping	❑	❑
Skin rash or itching	❑	❑	Frequent indigestion	❑	❑
Headaches	❑	❑	Nausea or vomiting	❑	❑
Loss of balance or coordination	❑	❑	Diarrhea or constipation	❑	❑
Hearing loss	❑	❑	Jaundice	❑	❑
Vision trouble	❑	❑	Rectal bleeding	❑	❑
Do you wear contacts or glasses?	❑	❑	Foul-smelling urine	❑	❑
Arm or leg weakness	❑	❑	Blood in urine	❑	❑
Sinus drainage	❑	❑			
Difficulty swallowing	❑	❑			
Hoarseness or change in voice	❑	❑			
Sores in mouth or lip	❑	❑			
Cough	❑	❑			
Coughed up or spit up blood	❑	❑			

URINARY SYMPTOMS	YES	NO
Check appropriate box:	❑	❑
Burning with urination	❑	❑
Urinating frequent, small amounts	❑	❑
Feeling like you need to urinate urgently! "or else….."	❑	❑
Lower abdominal pressure	❑	❑
Do you awaken at night to urinate?	❑	❑
If yes, how many times? _____	❑	❑
Do you pass air or "gas" in the urine?	❑	❑

URINARY TRACT INFECTIONS	YES	NO
1. Have you ever had any previous urinary infections (cystitis)? **If NO, go on to question 6**.	❑	❑
a) How many? _____		
b) Last infection _____		
c) At what age did they start? _____		
d) Related to sexual activity?	❑	❑
2. Did you ever have a high fever (102) with a urinary infection?	❑	❑
3. Did you ever have pain in the flank or kidneys with urinary infection?	❑	❑
4. Have you ever had X-rays of the kidneys (IVP) or bladder (Voiding Cystogram)?	❑	❑
5. Were you ever hospitalized to treat a urinary infection?	❑	❑
6. Have you ever had a sexually transmitted disease?	❑	❑
Check: ☐ Gonorrhea ☐ Chlamydia ☐ Herpes ☐ Genital Warts ☐ PID ☐ Other _____		

INCONTINENCE	YES	NO
Do you have leakage of urine (wetting of pants) with:		
a) Sneezing, coughing, straining	❑	❑
b) Laughing, walking	❑	❑
c) Upon arising from a sitting position	❑	❑
d) Sudden urge to urinate/cannot hold it until you get to the bathroom	❑	❑
e) During sexual intercourse	❑	❑
Do you use any pads for protection?	❑	❑
How many per day? _____		
Do you have to push or strain to empty the bladder?	❑	❑
Have you ever had a bladder suspension surgery?	❑	❑
If YES, through the Abdomen? ❑ Through the Vagina? ❑		

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

KIDNEY STONES	YES	NO
1. Do you have pain in the flank or kidney area?	❑	❑
If YES: ❑ Left ❑ Right		
2. Have you ever had a kidney stone?	❑	❑
3. If NO, skip to next section If YES, a) Date(s)? _____ b) How many? _____ c) Passed spontaneously? ❑ YES ❑ NO d) How was the stone removed? ❑ Surgically ❑ Basket e) Lithotripsy (shock waves)? ❑ YES ❑ NO		
4. What was the stone made of? ❑ Calcium ❑ Uric Acid ❑ Other: _____		
5. Were you placed on stone prevention therapy?	❑	❑
6. What type? _____		

HEMATURIA	YES	NO
1. Have you seen blood in your urine?	❑	❑
2. If NO, skip to question 5 If YES,		
a) Was the blood only at the beginning of the stream?	❑	❑
b) Throughout the stream?	❑	❑
c) At the end of the stream?	❑	❑
3. Was the bloody urine *(check all that apply)* ❑ Tea colored ❑ Rose wine/ cranberry colored ❑ Burgundy wine colored ❑ Clots		
4. Was there any pain or burning with the bloody urine?	❑	❑
5. Has a doctor found blood in your urine under a microscope?	❑	❑

SOCIAL HISTORY

(✓)	SUBSTANCE:	APPROXIMATE YEAR STARTED / FREQUENCY:
❑	ALCOHOL	Year: ☐ Never ☐ Rarely ☐ Occasional/Social ☐ Drinks/Day: _____
❑	SMOKING STATUS	❑ Current/Every Day ❑ Current/Some Days ❑ Former Smoker ❑ Never Smoker ❑ Unknown
❑	TOBACCO	Year: Pack(s) A Day: Quit: ☐ NO ☐ YES *If YES*, Date Quit:
❑	STREET DRUGS/OTHER	Year: Type: Do you use needles?
❑	HIV positive or AIDS	☐ YES ☐ NO

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

CURRENT MEDICATION LIST

DRUG NAME	DOSE	FREQUENCY	PRESCRIBING PHYSICIAN

ALLERGIES

☐ **No Known Allergies** ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Cipro ☐ Macrobid

MEDICATION	SPECIFIC TYPE OF REACTION

CONSENT TO ACCESS MEDICATION HISTORY

In order to provide you with the best possible care, your prescriptions will be written electronically whenever possible. Electronic prescribing is now a common practice due to healthcare initiatives requiring the use of electronic medical records. With your permission, e-prescribing will provide us access your medication history electronically, enabling us to see critically important information on your current and past prescriptions, better assess potential medication issues, and improve safety and quality of care.

By signing below I give my consent to Pacific Urology to access my medication history electronically and to the best of my knowledge, I verify that the above medical information is complete and correct. I understand that it is my responsibility to inform my physician if I ever have a change in my health.

*** **SIGNATURE**: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient

PREFERRED OUTSIDE PHARMACY

Name & Address (Location) of Preferred <u>OUTSIDE</u> Pharmacy: Is this is a MAIL ORDER PHARMACY? ❑ Yes ❑ No

Please list a local pharmacy for urgent prescriptions if primary is a mail order.
Name & Address of LOCAL pharmacy:

UROGYNECOLOGY
INCONTINENCE SYMPTOMS SCORE (ISS-8)

Please mark the appropriate answer to the best of your ability

1. Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating, had a weak stream, or had to push or strain to urinate?	___ Never ___ Less than half the time ___ About half the time ___ Almost always
2. Urgency Over the past month, how often have you found it difficult to postpone urination or experienced strong urge to urinate?	___ Never ___ Less than half the time ___ About half the time ___ Almost always
3. Nocturia (night urination) Over the past month, how many times did you most typically have to urinate?	___ None at night ___ Once or twice per night ___ Three to four times per night ___ Five or more times per night
4. Frequency to void during the day Over the past month, how often during the day did you typically have to urinate?	___ Every 3-4 hours or longer ___ Every 2-3 hours ___ Every 1-2 hours ___ Every half hour and/or less
5. Stress incontinence Over the past month, how often have you had urine leakage with activity such as coughing, sneezing, laughing or exercise?	___ Never ___ Less than once per week ___ At least once a week ___ At least once a day
6. Urge incontinence Over the past month, how often have you leaked because of a strong urge to urinate?	___ Never ___ Less than once per week ___ At least once a week ___ At least once a day
7. Urinary leakage with activity If you leak with activity, over the past month, at what level of activity did you experience leakage?	___ I do not leak (N/A) ___ Vigorous activity (running, jumping) ___ Moderate activity (cough/sneeze, lifting) ___ Minimal activity (walking,position change)
8. **Protection** Over the past month, how often have you used pads or panti-liners for urinary protection?	I use: Pads or Panti-liners (circle one) ___ Never ___ Only on certain occasions ___ Daily for occasional accidents ___ Daily for frequent accidents or constant leakage

Pelvic Floor Impact Questionnaire – Short form 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 **over the last 3 months.** Please make sure you mark an answer in **all 3 columns** for each question.

How are the below items of daily living affected by each of the following body systems?	***Bladder or urine***	***Bowel or rectum***	***Vagina or pelvis***
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

Pelvic Floor Disability Index (PFDI-20)

Instructions: 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 these by circling the appropriate number. While answering these questions, please consider your symptoms over the last 3 months. The PFDI-20 has 20 items and 3 scales of your symptoms. All items use the following format with a response scale from 0 to 4.

Symptom scale:

0 = not present
1= not at all
2 = somewhat
3 = moderately
4 = quite a bit

Pelvic Organ prolapse Distress Inventory 6 (POPDI-6)

Do You…	**NO**	**YES**
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1 2 3 4

Colorectal-Anal distress Inventory 8 (CRAD-8)

Do You…	**NO**	**YES**
7. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
9. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
10. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
11. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
12. Usually have pain when you pass your stool?	0	1 2 3 4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1 2 3 4

Urinary distress Inventory 6 (UDI-6)

Do You…	**NO**	**YES**
15. Usually experience frequent urination?	0	1 2 3 4
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	1 2 3 4
17. Usually experience urine leakage related to coughing, sneezing or laughing?	0	1 2 3 4
18. Usually experience small amounts of urine leakage (that is, drops)?	0	1 2 3 4
19. Usually experience difficulty emptying your bladder?	0	1 2 3 4
20. Usually experience pain or discomfort in the lower abdomen or genital region?	0	1 2 3 4

Scoring the PFDI-20

Scale Scores: Obtain the mean value of all of the answered items within the corresponding scale (possible value 0 to 4) and then multiply by 25 to obtain the scale score (range 0 to 100). Missing items are dealt with by using the mean from answered items only.

PFSI-20 Summary Score: Add the scores from the 3 scales together to obtain the summary score (range 0 to 300).