Andrey Petrikovets, MD, FACOG

Female Pelvic Medicine and Reconstructive Surgery
Advanced Minimally Invasive Gynecologic Surgery

Welcome to the office of **Andrey Petrikovets, MD, FACOG**, a practice dedicated to the care of pelvic floor disorders affecting women. Dr. Andrey is one of the few surgeons in the United States trained in Female Pelvic Medicine/Reconstructive Surgery and Advanced Minimally Invasive Gynecologic Surgery. He is trained to provide specialty consultation and management of the full spectrum of female pelvic floor disorders, including pelvic organ prolapse, urinary incontinence, overactive bladder, incomplete bladder emptying, difficult defecation, accidental bowel leakage, painful bladder syndrome, recurrent urinary tract infections, urethral diverticulum, fistulas, abnormal uterine bleeding, fibroids, and endometriosis.

Dr. Andrey takes pride in staying ahead of the latest innovations to bring patients the most current therapies and minimally invasive procedures coupled with attention to personalized service.

On your first visit, Dr. Andrey will carefully and thoroughly review your medical history, perform a comprehensive pelvic exam, and conduct various tests to determine and discuss with you the best course of treatment. Throughout the entire process, your comfort, privacy, and health concerns will be given the utmost priority.

Enclosed is a questionnaire that will help us in your evaluation and treatment. It is very important that you complete this form as thoroughly as possible.

During your first visit **DO NOT** EMPTY YOUR BLADDER UNTIL INSTRUCTED BY THE MEDICAL ASSISTANT.

We look forward to taking care of all your pelvic floor needs!

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Name: _____ **Date:** _____

Age: _____ **Date of Birth:** _____ **Race:** _____

Email:

Primary Care Physician: _____

Address/Phone#: _____

Referring Physician: _____

Address/Phone#: _____

How did you hear about us? (Please circle all that apply): DOCTOR (name): _____
FRIEND INTERNET NEWSPAPER ADVERTISEMENT OTHER _____

CHIEF COMPLAINT: _____

Please tell us about it: _____

Please [✔] box if you answer "YES" to the following questions:

☐ Do you feel like you urinate too frequently? If yes, how often (in minutes or hours)? _____

☐ Do you ever feel an urge to urinate that you fear you cannot control?

☐ Do you ever leak urine with this urge?

☐ Have you ever taken medications to control your urge to urinate or to control how often you urinate? If so, what medication? _____

☐ Do you have trouble starting your urine stream?

☐ Is your urine stream weak?

☐ Does your urine stream start and stop frequently?

☐ Do you ever have to strain or push to urinate?

☐ Do you use pads/pantiliners because of urine leakage? If so, how many per day? _____

How many times during the **day** do you use the bathroom to urinate? _____

☐ Have you ever had blood in your urine?

How many times at **night** do you wake up to use the bathroom because of an urge to urinate? _____

☐ Do you feel like you don't empty your bladder completely?

☐ Do you have pain with a full bladder?

☐ Do you leak urine with coughing/sneezing/dancing/laughing/activity?

☐ Do you leak urine during intercourse?

☐ Do you have frequent bladder infections? If yes, how many in 6 months? _____ 12 months? _____

☐ Have you ever had kidney stones?

☐ Do you feel a bulge in your vagina?

If yes, does it bother you? ☐

If yes, how long have you had a bulge? ____

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☐ Have you ever been told that your vagina/bladder/rectum/uterus are falling?

☐ Do you ever have trouble with your bowel movements?

☐ Have you ever used a "Pessary?"

☐ Have you ever had surgery for your vagina/bladder/rectum/uterus?

How many bowel movements do you have a week? _____

☐ Do you strain to have a bowel movement?

☐ Do you ever have hard stool?

☐ Do you have watery stool?

☐ Do you ever leak from your rectum when you do not want to? If so, ☐ stool? ☐ gas?

☐ Are you interested in aesthetic/cosmetic surgery for your labia and/or vagina?

☐ Are you unhappy with the appearance of your labia/vagina?

☐ Do you feel that you have vaginal laxity?

☐ Do you ever have to push on this bulge in the vagina to urinate or have a bowel movement?

☐ Are you sexually active?

☐ If you are sexually active, do you experience pain during sex?

☐ If you are sexually active, is your sex life satisfactory for you?

☐ Do you experience vaginal dryness/burning?

☐ Have you gone through menopause?
☐ If yes, are you are you experiencing any vaginal bleeding **after** menopause?

☐ How long has it been since your last period?
_____

Is there anything else we should know (all information is confidential)_____
_____
_____
_____
_____

OBSTETRIC HISTORY

_____ Number of pregnancies total

_____ Number of children born

_____ Number of cesarean sections

_____ Weight of largest baby

_____ Number of vaginal deliveries

During vaginal delivery, did you ever have:

☐ A tear into the rectum? ☐ Forceps?
☐ Vacuum?

GYNECOLOGIC/CANCER SCREENING HISTORY

When was your last pap smear? _____
Was it normal? _____

☐ History of endometriosis

☐ History of fibroid uterus

☐ History of gynecologic surgery

When was your last mammogram? _____
Was it normal? _____

When was your last colonoscopy? _____

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Was it normal? _____

PAST MEDICAL HISTORY Please [✔] if you answer "YES" to the following questions:

☐ Heart disease	☐ COPD	☐ Parkinson's Disease
☐ Heart Attack	☐ Bowel Disease	☐ Alzheimer's Disease
☐ High Blood Pressure	☐ Stroke	☐ Cancer: Type _____
☐ Kidney Disease	☐ Arthritis	☐ Depression/Bipolar
☐ HIV	☐ Glaucoma	☐ History of Clots/DVT/PE
☐ Diabetes	☐ Asthma	☐ Bleeding Disorders
☐ Liver Disease	☐ Neurologic Disease	☐ Fibromyalgia
☐ Thyroid Disease	☐ Multiple Sclerosis	☐ Other: _____

SURGICAL HISTORY

If you have had any operations, please list them here:

SURGERY	DATE	SURGEON

MEDICATIONS/OTHER DOCTORS

Please tell us who your other **DOCTORS** are and what other **MEDICATIONS** they prescribe? If possible, please include the doses.

Do you have any drug allergies? ☐ Yes ☐ No. If yes, to which medications?
_____ **Do you take any herbal supplements?** ☐ Yes ☐ No If yes, which?
_____

DOCTOR: _____**MEDICATIONS:**_____

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DOCTOR: _____**MEDICATIONS:**_____

DOCTOR: _____**MEDICATIONS:**_____

DOCTOR: _____**MEDICATIONS:**_____

DOCTOR: _____**MEDICATIONS:**_____

SOCIAL/FAMILY SUPPORT HISTORY **Please [✔] if you answer "YES" to the following questions:**

☐ Tobacco use? If yes, how many cigarettes do you smoke per day? _____

☐ Marijuana use? If yes, how much do you consume per day? _____

☐ Alcohol use? If yes, how many drinks per week?
_____

☐ Coffee use? If yes, how much coffee do you drink per day? _____

☐ Other drug use? If yes, what other drugs do you use (all information is confidential)?
_____

How much water do you drink on average per day? _____

How many times a week do you exercise? _____

Do you consider yourself healthy? _____

Who is your main support person (partner/spouse/friend)? _____

FAMILY HISTORY

Has anyone in your family ever had any of these diseases/conditions?

Breast cancer_____

Ovarian cancer _____

Uterine cancer _____

Kidneys/bladder cancer_____

Diabetes _____

Heart Disease/Heart Attack_____

Other Cancer or Diseases_____

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Incontinence Severity Index (ISI)

Please answer the following two (2) questions:

1. **How often do you experience urinary leakage (Please check one)**

   _____ Never, I do not leak urine

   _____ Less than once a month

   _____ A few times a month

   _____ A few times a week

   _____ Every day and/or night

2. **How much urine do you lose each time? (Please check one)**

   _____ None, I do not leak urine

   _____ Drops

   _____ Small splashes

   _____ More

Thank you for answering these questions. Continue on to next page…

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REVIEW OF SYSTEMS

Please [✔] if you answer "YES" if you have had any of the following symptoms in the past month.

General
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Fevers, Chills
- ☐ Weight Gain
- ☐ Weight Loss

Ears, Nose, Throat
- ☐ Runny nose
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Sinus problems
- ☐ Sore mouth
- ☐ Sore throat

Eyes
- ☐ Vision Changes

Skin/Hair
- ☐ Hair loss
- ☐ Lesions
- ☐ Rash
- ☐ Worrisome mole

Allergy/Immunologic
- ☐ Hay fever
- ☐ HIV exposure
- ☐ Hives
- ☐ Persistent infections

Breast
- ☐ Breast Lump

Respiratory
- ☐ Cough
- ☐ Short of breath while lying down
- ☐ Post-nasal drip
- ☐ Short of breath
- ☐ Wheezing

Cardiovasular
- ☐ Chest pain
- ☐ Leg pain with motion
- ☐ Swelling in legs
- ☐ Palpitations
- ☐ Swelling elsewhere

Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst
- ☐ Excess amount of urine

Hematologic/Lymphatic
- ☐ Abnormal bruising
- ☐ Excess bleeding
- ☐ Swollen lymph glands

Genitourinary
- ☐ Burning with urination
- ☐ Urinary frequency
- ☐ Blood in urine
- ☐ Kidney stones

Gynecologic
- ☐ Incontinence
- ☐ Menstrual irregularity
- ☐ Vaginal discharge
- ☐ Vaginal dryness
- ☐ Vaginal itching
- ☐ Vaginal discomfort
- ☐ Sexual dysfunction

Gastrointestinal
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Blood in stool
- ☐ Nausea
- ☐ Vomiting

Musculoskeletal
- ☐ Back pain
- ☐ Neck pain
- ☐ Joint pain
- ☐ Stiffness

Psychology
- ☐ Sleep problems
- ☐ Depression
- ☐ Anxiety
- ☐ Suicidal thoughts
- ☐ Hallucination

Neurologic
- ☐ Headache
- ☐ Weakness
- ☐ Numbness
- ☐ Memory loss
- ☐ Tingling

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Pelvic Floor Impact Questionnaire (PFIQ)

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	Vagina or Pelvis
1. Ability to do household chores (cooking, cleaning, 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
2. Ability to do physical activities, such as walking, swimming, or other exercise?	☐ Not at all ☐ Somewhat ☐ Moderately	☐ Not at all ☐ Somewhat ☐ Moderately	☐ Not at all ☐ Somewhat ☐ Moderately
3. Entertainment activities, such as going to a movie or concert?	☐ Not at all ☐ Somewhat ☐ Moderately	☐ Not at all ☐ Somewhat ☐ Moderately	☐ Not at all ☐ Somewhat ☐ Moderately
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	☐ Not at all ☐ Somewhat ☐ Moderately	☐ Not at all ☐ Somewhat ☐ Moderately	☐ Not at all ☐ Somewhat ☐ Moderately
5. Participating in social activities outside your home?	☐ Not at all ☐ Somewhat ☐ Moderately	☐ Not at all ☐ Somewhat ☐ Moderately	☐ Not at all ☐ Somewhat ☐ Moderately
6. Emotional health (nervousness, depression, etc.)?	☐ Not at all ☐ Somewhat ☐ Moderately	☐ Not at all ☐ Somewhat ☐ Moderately	☐ Not at all ☐ Somewhat ☐ Moderately
7. Feeling frustrated?	☐ Not at all ☐ Somewhat ☐ Moderately	☐ Not at all ☐ Somewhat ☐ Moderately	☐ Not at all ☐ Somewhat ☐ Moderately

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Pelvic Floor Disease Inventory Questionnaire – 20 (PFDI-20)

Please answer all of the questions in the following survey. The questions will ask you if you have certain bowel, bladder, or pelvic symptoms and if you do how much do they bother you. Answer each question by putting an X in the appropriate box or boxes. If you are unsure about how to answer, please give the best answer you can.

			If yes, how much does it bother you?			
			Not at all	Somewhat	Moderately	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 ☐	☐	☐	☐	☐

			If yes, how much does it bother you?			
			Not at all	Somewhat	Moderately	Quite a bit
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	D 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 of discomfort in the lower abdomen or genital region?	YES ☐ NO ☐	☐	☐	☐	☐