Welcome to the Center for Urogynecology and Reconstructive Pelvic Surgery

At the Center for Urogynecology and Reconstructive Pelvic Surgery, our goal is to provide diagnostic and therapeutic options tailored to a patient’s health needs. We offer comprehensive evaluation of the pelvic floor and recommended an individual treatment plan.

We are committed to providing you with the highest quality of healthcare.

Doctor Gopal completed his fellowship training at the Hospital of the University of Pennsylvania. He has published in peer reviewed journals, textbooks and he has presented at national and international scientific meetings, such as the American Urogynecologic Society and International Continence Society.

He is currently Chief of Robotics at Saint Peters University Hospital and has been chosen by his peers as a Top Doctor in his field in the State of New Jersey 2016, 2017 and 2018

Our office locations are listed below:

49 Veronica Ave., Suite 207, Somerset, New Jersey 08873
111 Union Valley Rd., Suite 205, Monroe, New Jersey 08831
900 West Main Street, Suite 3 Freehold NJ 07728
1 Route 70 West, Lakewood, New Jersey 08701

You can reach our office Monday through Friday 8:30 am to 5pm at 877-987-6496
What you should know about Urogynecology

Urogynecology treats problems affecting the female pelvic floor – the urologic gynecologic, and rectal organs, which along with the pelvic floor muscles, occupy the space between the pubic bone and the tail bone.

Why do I need a Urogynecologist?

As the name implies, Urogynecologist have their expertise in gynecology, urology and bowel dysfunction in women. Do to the close proximity of the pelvic organs, there is a frequent Coexistence of problems in adjacent organs. As such women with a “dropped” vagina may also have urinary incontinence or experience problems with bowel movements. It is estimated that more than 45% of women will at some point have problems with bladder control, 10% have problems with prolapse (dropping) of the pelvic organs, and 10% of women will require surgery for correction of these problems.

What is Urinary Incontinence?

Commonly known as lack of bladder control, Urinary Incontinence is a common problem in adult women. There are various types of Urinary Incontinence. Your Urogynecologist will evaluate your bladder function in order to precisely determine what is causing your bladder problem. This will allow him/her to recommend treatments specifically designed for your care. In order to evaluate your bladder function, you may be asked to complete a bladder diary, undergo a full pelvic exam, undergo bladder function testing (Urodynamic Testing) or undergo a Cystoscopy to examine the inside of your bladder.

What is Vaginal/Uterine Prolapse?

Due to the weakness of connective tissues, the Uterus, Vagina, Bladder, or Rectum can drop into the vaginal canal and even into the vaginal opening. This is termed Prolapse. This is analogous to a hernia which can occur along the lower abdomen due to weakness of the tissue of the lower abdominal wall. Prolapse can result in problems affecting the organ which has prolapsed. Urinary Incontinence if the bladder has prolapsed, problems with bowel movements if the rectum has prolapsed.

What Treatments are Available?

Based on your complete evaluation, your Urogynecologist will recommend treatment specifically designed for your case. They will likely be a few options to choose from. The options may include non-surgical treatment such as pelvic floor exercises, oral medications, patch or intra-vaginal devices to help elevate vaginal prolapse, or surgical therapy to correct the anatomic defects.
Pelvic Floor Muscle Rehab (PFMR) Therapy for Urinary Incontinence

What is PFMR?

PFMR can help you learn how to do effective pelvic muscle exercises that strengthen the muscle supports around the bladder, urethra, and rectum. Weak muscles can contribute to stress incontinence and bowel incontinence. PFMR is also used to treat muscle dysfunction. When muscles are weak or damaged, it can be difficult to know whether the appropriate muscles are being exercised and whether they are being exercised with the proper technique.

How Does PFMR Work?

PFMR involves the use of special electronic or electrical equipment to display information about your pelvic floor muscles. This information is transmitted by small sensors to a unit that creates a picture image on a screen. The visual image may be color bars or a polygraph display (like an EKG tracing). This information communicates the muscle strength, endurance, and function.

Doctors use PFMR to instruct and coach patients in the best ways to improve their muscle function. This may hasten the progress that you make in a pelvic muscle retraining program.

Because you learn the most effective techniques right away, you can concentrate on the strengthening exercises. Also, the techniques you learn during PFMR treatment sessions can be repeated during home practice sessions.

Without PFMR, some people with weak or damaged muscles have more difficulty identifying the pelvic muscles and exercising them to their full capacity.

How Is It Done?

The body signals are transmitted by way of an internal and external sensing device. For instance, an internal tampon-like device is fitted into the vagina, and a similar smaller device is placed in the rectum. External patches are also placed on the abdominal area.

The procedure is safe and non-invasive. None of these devices deliver any electrical current. The primary purpose is to detect and transmit the functioning of the muscle activity so that the person can look at a screen to associate the sensations that are felt during the pelvic muscle exercise with the picture on the screen. This helps the person identify and contract the correct muscles.

Most people are unaware of the pelvic muscles and how they contribute to bladder control. PFMR helps you learn how to become more aware of these important muscles and to use them regularly to improve bladder control.
PFMR can offer such benefits as...

Helping to visualize and identify appropriate muscles; Helping to focus on exercising the correct muscle groups; Reinforcing efforts to perform the exercise correctly; Teaching how to repeat the exercise correctly; Motivating you to take control of your bladder problem; Recording progress at each session with computer print outs.

What Is The Treatment Plan?

At each session, the information collected about your pelvic muscle strength, endurance, and function helps your doctor develop different exercise strategies for continued improvement of your muscle function. Everyone will have slightly different treatment plans based on their muscle function. Your treatment plan is developed by you and your doctor together, to determine the most practical and effective approaches for muscle training.

How Long Does It Take?

PFMR sessions may take between 15 and 45 minutes, depending upon the goals of the session. Most people find the PFMR sessions interesting and helpful. Between 6 and 8 PFMR sessions may be needed for pelvic muscle re-training.

Tips For Self Care

PRACTICE:
When practicing pelvic muscle exercises at home be sure to set aside tune when you can concentrate on performing the exercises as done with biofeedback. Focus on the quality of the contraction, the intensity and the duration.

FOLLOW-UP:
Attend your follow-up sessions; even if you fell you have not practiced your pelvic muscle exercises enough. Usually, the PFMR session will reveal improvements in muscle awareness, control, and function, even if strength has not increased. Even when muscles are exercised a little, there can be some improvements in function. Plus, the PFMR session will motivate you to continue the exercise program.
PROVEN EFFECTS, OUTSTANDING RESULTS

Scientific research has shown that 95% of treated patients reported significant improvement in their quality of life.*

ASK YOUR PROVIDER ABOUT BTL EMSELLA™ TODAY:

INFO@BTLNET.COM
EMSELLA.COM

BTL EMSELLA™

SAY NO TO INCONTINENCE

SAY NO TO INCONTINENCE

A Breakthrough Treatment for Incontinence

* HIFEM Technology Can Improve Quality of Life in Incontinent Patients
Berenfeld J., MD, Sims T., MD, Botros G., MD
Individual results may vary.
BTL Emsella™

Sit and experience the breakthrough treatment for incontinence.

"I have regained my confidence because of my treatment and intend to resume my sport activities."
Amanda, Houston, TX

"To my amazement I shut off a medium strong stream. I could not do that before!"
Karen, Boston, MA

WHO IS THE RIGHT CANDIDATE FOR BTL Emsella™?
BTL Emsella™ is a great option for women of any age who desire solution for urinary incontinence and improvement in their quality of life.

WHAT DOES THE PROCEDURE FEEL LIKE? IS IT PAINFUL?
You will experience tingling and pelvic floor muscles' contractions during the procedure. You may resume daily activities immediately after the treatment.

HOW LONG IS THE TREATMENT? HOW MANY SESSIONS DO I NEED?
Your provider will tailor a treatment plan for you. A typical treatment takes about 30 minutes and you will need about 6 sessions, scheduled twice a week.*

HOW FAST WILL I SEE RESULTS?
You may observe improvement after a single session. The results will typically continue to improve over the next few weeks.

BODY AGING, CHILDBIRTH, AND MENOPAUSE CAN LEAD TO INCONTINENCE.

BEFORE
Pelvic floor muscles insufficiently support pelvic organs and affect bladder control.

TREATMENT
BTL Emsella™ effectively stimulates pelvic floor muscles.

AFTER
Stimulation leads to regained control over pelvic floor muscles and bladder.
HOW DO PRP INJECTIONS WORK?

PRP therapy uses injections of concentrated platelets of the patient's own blood to naturally enhance the healing process of the damaged cells. The blood's platelets contain proteins and other growth factors needed to accelerate the cell's healing process.

“THE RESULTS SURPASSED MY EXPECTATIONS. IT HAS CHANGED [MY CLIENT'S] LIFE”

Patient had deep pitted facial acne scarring. Patient was treated utilizing a microneedling device and Integrity PRP products.
WHAT IS PRP?
Platelet-rich plasma (PRP) is an autologous concentrated preparation of platelets and the associated growth factors in a small volume of plasma. Platelets release growth factors, which regulate the healing cascade by signaling to surrounding cells to repair damaged tissue and regenerate new tissue.

WHY PRP?
The use of platelet-rich plasma has become recognized as an all natural approach to anti-aging without the need for extensive or expensive surgery.

BENEFITS OF PRP

Additional Benefits of PRP Therapy:
- Acne scarring and wound healing
- Thinning hairline
- Sexual rejuvenation
- Treats urinary incontinence and overactive bladder
- Joint pain
- Osteoarthritis
Center for Urogynecology and Reconstructive Pelvic Surgery
Manish Gopal M.D. M.S.C.E

PLEASE PRINT CLEARLY AND COMPLETE ALL AREAS

Last Name: ____________________________  First Name: ____________________________

Middle Name: ____________________________

Social Security #: ____________________________  Date of Birth: ________ - ________ - ________  Age: ________

Address: ____________________________  City: ____________________________  State: ________  Zip: ________

Married □  Single □  Widow □

Race: ____________________________  Ethnic Background: ____________________________  Preferred Language: ____________________________

Home Phone: ____________________________  Daytime Phone: ____________________________  Cell Phone: ____________________________

Email Address: ____________________________  Emergency Contact: ____________________________  Phone: ____________________________  Relationship: ____________________________

Referring Physician Name: ____________________________  Phone: ____________________________  Fax: ____________________________

Primary Care Physicians Name: ____________________________  Phone: ____________________________  Fax: ____________________________

Address: ____________________________  City: ____________________________  State: ________  Zip: ________

Gynecologists Name: ____________________________  Phone: ____________________________  Fax: ____________________________

Address: ____________________________  City: ____________________________  State: ________  Zip: ________

Pharmacy Name: ____________________________  Address: ____________________________  Phone: ____________________________

INSURANCE INFORMATION:

Primary Insurance Name: ____________________________  ID#: ____________________________  Group#: ____________________________

Name of Insured: ____________________________  Date of Birth: ____________________________  Copay Amount: ____________________________

Policy Holder Relationship: □ Self □ Spouse □ Partner □ Other

Secondary Insurance Name: ____________________________  ID#: ____________________________  Group#: ____________________________

Name of Insured: ____________________________  Date of Birth: ____________________________  Copay Amount: ____________________________

Policy Holder Relationship: □ Self □ Spouse □ Partner □ Other

I authorize the release of medical information to process the claims for medical benefits and any payment of medical benefits to Lifeline Medical Associates LLC. I agree to pay all costs of collection, attorney’s fees associated with collection due to services rendered and performed. I am financially responsible to Lifeline Medical Associates, LLC and its successors and assigns and any individual it may designate for balance not covered by insurance. I authorize the release of medical information to any providers and facilities participating in my care under HIPPA regulations.

__________________________  ____________________________ (Expires 2 years from date)
Signature of Patient or Guardian  Date

__________________________  ____________________________ (Expires 2 years from date)
Signature of Patient or Guardian  Date
### PAST MEDICAL HISTORY FORM

**NAME:** ________________________________ **BIRTH DATE:** ___/___/____ **DATE:** ___/___/____

**PLEASE CHECK (X) IF YOU HAVE OR HAD ANY OF THE FOLLOWING:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>CURRENTLY</th>
<th>PAST</th>
<th>NOTES</th>
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<tbody>
<tr>
<td>Weight loss</td>
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<td>Weight gain</td>
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<td>Fever</td>
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<td>Fatigue</td>
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<td>Double vision</td>
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<td>Spots before eyes</td>
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<tr>
<td>Vision changes</td>
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<tr>
<td>Ear aches</td>
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<tr>
<td>Ringing in ears</td>
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<td>Sinus problems</td>
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<td>Sore throat</td>
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<tr>
<td>Mouth sores</td>
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<td>Dental problems</td>
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<tr>
<td>Painful breathing</td>
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<tr>
<td>Chest pain</td>
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<td>Difficult breathing:</td>
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<td>On exertion</td>
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<td>Swelling of legs</td>
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<td>Palpitations of heart</td>
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<td>Wheezing</td>
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<td>Spitting up blood</td>
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<tr>
<td>Shortness of breath</td>
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<tr>
<td>Cough, chronic</td>
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<td>Diarrhea, frequent</td>
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<td>Bloody stool</td>
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<tr>
<td>Nausea/vomiting</td>
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<td>Constipation</td>
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<tr>
<td>Blood in urine</td>
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<td></td>
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<tr>
<td>Pain with urination</td>
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<tr>
<td>Urgency</td>
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<td></td>
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<tr>
<td>Frequency of urination</td>
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<td></td>
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<tr>
<td>Incomplete emptying</td>
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<tr>
<td>Stress incontinence</td>
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<tr>
<td>Abnormal periods</td>
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<tr>
<td>Painful intercourse</td>
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</table>
## Past Medical History Form

### Please Check (X) if you have or had any of the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Currently</th>
<th>Past</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td>Muscle weakness</td>
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<td>NOTES</td>
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<tr>
<td>Pain in breast</td>
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<tr>
<td>Nipple Discharge</td>
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<td>Masses/Lumps</td>
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<td>Rashes</td>
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<tr>
<td>Ulcers</td>
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<td>NOTES</td>
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<td>Dizziness</td>
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<tr>
<td>Seizures</td>
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<tr>
<td>Numbness</td>
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<tr>
<td>Trouble walking</td>
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<tr>
<td>Depression</td>
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<tr>
<td>Crying, frequent</td>
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<td>Dry skin</td>
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<td>Abnormal thirst</td>
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<tr>
<td>Hot flashes</td>
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<tr>
<td>Bruises, frequent</td>
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<tr>
<td>Cuts do not stop</td>
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<tr>
<td>bleeding</td>
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<td>NOTES</td>
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<tr>
<td>Enlarged lymph nodes</td>
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<tr>
<td>Allergies</td>
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<tr>
<td>Drugs, other</td>
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<td>NOTES</td>
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</table>

### Major Illnesses: Yes No

- Asthma Cancer:  □ YES  □ NO
- Pneumonia Ulcers:  □ YES  □ NO
- Chronic Lung Disease:  □ YES  □ NO
- Depression/anxiety:  □ YES  □ NO
- Kidney Infections/stones:  □ YES  □ NO
- Anemia/Blood transfusions:  □ YES  □ NO
- Tuberculosis:  □ YES  □ NO
- Seizures/convulsions/epilepsy:  □ YES  □ NO
- Venereal Disease:  □ YES  □ NO
- Bowel trouble:  □ YES  □ NO
- Heart Trouble/murmur:  □ YES  □ NO
- Glaucoma:  □ YES  □ NO
- Diabetes Arthritis/joint pain:  □ YES  □ NO
- High Blood Pressure:  □ YES  □ NO
- Fracture:  □ YES  □ NO
- Stroke:  □ YES  □ NO
- Hepatitis/Yellow jaundice:  □ YES  □ NO
- Rheumatic Fever:  □ YES  □ NO
- Thyroid Disease:  □ YES  □ NO

Other Explain:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
**OPERATIONS/HOSPITALIZATIONS**

<table>
<thead>
<tr>
<th>Reason</th>
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**INJURIES/ILLNESSES**

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<th>Type</th>
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**LAST IMMUNIZATION OR TEST**

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<tr>
<th>Type</th>
<th>Date</th>
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<th>Date</th>
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<tbody>
<tr>
<td>Flu Shot</td>
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<td>TB Skin Test</td>
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<tr>
<td>Pneumonia</td>
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<td>Tetanus</td>
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<tr>
<td>Other:</td>
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**OB/GYN HISTORY**

<table>
<thead>
<tr>
<th>Number</th>
<th>Type</th>
<th>Number</th>
<th>Type</th>
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<tbody>
<tr>
<td></td>
<td>Births</td>
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<td>Abortion</td>
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<tr>
<td></td>
<td>Miscarriages</td>
<td></td>
<td>Living Children</td>
</tr>
</tbody>
</table>

**CURRENT MEDICATIONS**

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosage</th>
<th>Drug Name</th>
<th>Dosage</th>
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</tbody>
</table>
FAMILY HISTORY

High Blood Pressure  ☐ NO ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Other___________
Heart Disease  ☐ NO ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Other___________
Stroke  ☐ NO ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Other___________
Diabetes  ☐ NO ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Other___________
Drinking Problem  ☐ NO ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Other___________
Breast Cancer  ☐ NO ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Other___________
Colon Cancer  ☐ NO ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Other___________
Ovarian Cancer  ☐ NO ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Other___________
Other Cancers  ☐ NO ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Other___________

SOCIAL HISTORY

Habits
Smoking  ☐ YES ☐ NO Packs / day______ Years______ If no longer smoking when did you quit? ______
Alcohol  ☐ YES ☐ NO Drinks / day______ Drinks / week______ If no longer drinking when did you quit? ______
Drug Use  ☐ YES ☐ NO
Seat Belt Use  ☐ YES ☐ NO
Regular Exercise  ☐ YES ☐ NO

Personal Profile

Marital Status:
Married ☐ Single ☐ Widowed ☐ Divorced ☐
Number of Living Children___________
Number of people in household___________
Education Completed: High School ☐ College ☐ Graduate Degree ☐ Other ☐
Current or most recent Job

During your examination your bladder may need to be emptied by for Dr. Gopal to exam you thoroughly. This will be done by the method of catheterization.

Signature of patient: ____________________________ Date: ________________

Physician Signature: ____________________________ Date: ________________
Center for Urogynecology and Reconstructive Pelvic Surgery — Manish Gopal MD

For compliance with CMS and Medicare Services — PQRS please complete the questions below.

Date: ____________
Name: ___________________________________________ Age: ____________

When was your last Pap Smear?
  Approximate month and year ____________
  ☐ Never had one
  Where was it done? ____________________________

When was your last Mammogram?
  Approximate month and year ____________
  ☐ Never had one
  Where was it done? ____________________________

When was your last DEXA Scan (Bone Density Test)
  Approximate month and year ____________
  ☐ Never had one
  Where was it done? ____________________________

If you have Osteoporosis have you ever had a fracture due to this condition?
  ☐ Yes  ☐ No

When was your last Colonoscopy?
  Approximate month and year ____________
  ☐ Never had one
  Where was it done? ____________________________

Have you had a Flu Shot?  ☐ No  ☐ Yes
  Approximate month and year ____________

Have you a Pneumonia Vaccine?  ☐ No  ☐ Yes
  Approximate month and year ____________

THANK YOU FOR YOUR COOPERATION
CONSENT FORM

Manish Gopal MD  Lifeline Medical Associates
Center for Urogynecology and Reconstructive Pelvic Surgery

Name: ___________________________ DOB: __________________

Consent for Bladder Catherization
This Consent will cover all visits with Physician
At any time you wish to change your consent please inform physician

Bladder Catherization is done for multiple reasons for patients being seen with Urinary and Pelvic issues: To obtain a clean specimen from containing vaginal bacteria, to measure if the bladder is emptying completely after urination and to determine if a urinary tract infection or inflammation is present. It also enables the physician to obtain a better pelvic exam with the bladder completely empty.

Yes, I give my consent to o Bladder Catherization.
if physician deems necessary.

Please sign below:
Signature: ___________________________ Date: ________________

☐ Patient refused Catheterization
MA: ____________________________
Medical Records Release

Records Released From:

Patient Name: ___________________________ DOB: ________________

I ___________________ Herby authorize Release of my medical records to:

Urogyneology Associates of Central Jersey, PC – Manish Gopal MD

☐ Complete Medical Record

☐ All Laboratory – Radiology – Hospital and Operative Records

Office Notes From DOS: ___________________________

☐ Mail

Send to Address: 49 Veronica Avenue Suite 207, Somerset New Jersey 08873

☐ Fax

Fax (732) 640-5320 or Fax (732) 578-6568

Patient Signature: ___________________________

Date: ___________________

Records Sent via: ☐ Mail ☐ Fax

49 Veronica Ave., Ste 207, Somerset, NJ 08873

Phone (877) 987-6496 - Fax (732) 640-5320 - www.urogynnj.com