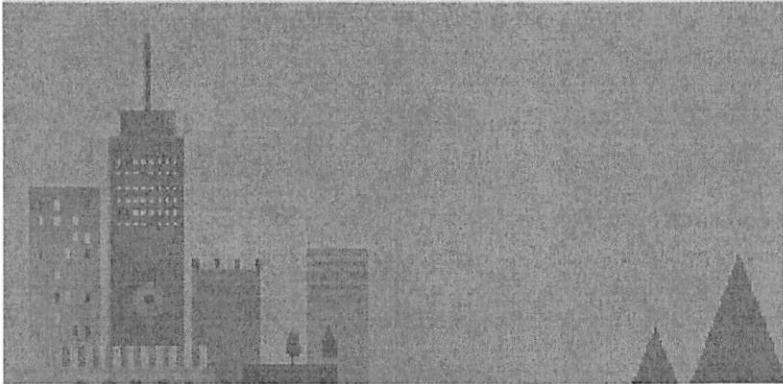


# Google Maps 7162 Liberty Centre Dr Suite B



7162 Liberty Centre Dr Suite B  
West Chester Township, OH 45069

ADVANCED PELVIC SURGERY L.L.C.  
Dr. R. Gregory Owens  
7162 Liberty Centre Drive Suite B  
West Chester, Ohio 45069

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## **WHAT TO EXPECT**

On your first visit with Dr. Owens you will discuss your history with Dr. Owens. Please bring the forms mailed to you filled out with specific information regarding medications and dosages, previous surgeries, allergies, and other medical problems. A vaginal exam, similar to what you have at your gynecologist's office, will be conducted. This exam is important to identify structural problems with the vaginal wall, urethra, bladder, and uterus. Each phase of the examination procedure will be explained. Please do not hesitate to ask questions.

If needed, a second visit will be scheduled for urodynamic testing. Urodynamic testing is a set of diagnostic procedures designed to evaluate lower urinary tract and pelvic floor function. The lower urinary tract includes the bladder and urethra and works in concert with your pelvic floor muscles. The bladder and urethra operate as a single unit, but have different functions. To store urine, the bladder relaxes while the urethra and pelvic floor muscles contract to help hold the urine in the bladder. To empty urine, the bladder contracts and the urethra and pelvic floor muscles relax. A small catheter will be introduced into your bladder to obtain a measurement of the urine left in your bladder after you have emptied. Next, very small catheters will be placed into the bladder and vagina. These catheters are attached to the urodynamic computer, and give information regarding bladder volumes, pressures, etc. As your bladder is being filled with sterile water, you will be asked to identify the first sensation in your bladder, the point you would normally go to the bath room, and the maximum amount you can hold in your bladder. The filling of your bladder will stop at various intervals to have you cough and bear down to stimulate conditions that would cause you to leak urine during a normal day. After this is completed, you will be asked to empty your bladder in privacy.

After the procedure is completed, Dr. Owens will discuss the results with you and formulate a plan of care that meets your needs. Please notify the office before your appointment if you are currently being treated for a bladder infection, or have any other infections diagnosed in the vaginal or urinary tract area. Please do not hesitate to call the office at 513-942-7640 with any questions.



**New Patient Consult HPI (PLEASE PRINT)**

Date of visit \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Primary Doctor \_\_\_\_\_

What is the main reason for your visit?  
\_\_\_\_\_  
\_\_\_\_\_

How long have you had the problem? \_\_\_\_\_

What makes it better or worse? \_\_\_\_\_

Please list all your bladder, bowel or GYN surgeries \_\_\_\_\_  
\_\_\_\_\_

Do you have urine loss with coughing or activity? [Yes] [No] With the urge to void? [Yes] [No] Do you have urinary urgency without leaking? [Yes] [No]

How many times a day? \_\_\_\_\_ Do you need pads? [Yes] [No] How many a day? \_\_\_\_\_

Do you have problems starting your urine stream? [Yes] [No] Slow stream? [Yes] [No] Emptying your bladder [Yes] [No] Dribbling? [Yes] [No]

How long can you go between urinations during the day? \_\_\_\_\_ How many times do you void at night? \_\_\_\_\_ Do you wet the bed? [Yes] [No]

When was your last urinary tract infection? \_\_\_\_\_ Have you ever had kidney stones or blood in your urine? [Yes] [No] If so, what was done to treat it? \_\_\_\_\_

How often do you move your bowels? \_\_\_\_\_ Do you have trouble moving your bowels? [Yes] [No] If so what is the trouble? \_\_\_\_\_

Do you have problems controlling gas? [Yes] [No] Liquid Stool? [Yes] [No] Solid stool? [Yes] [No] If so, how often do you have accidents? \_\_\_\_\_ Do you need pads for stool incontinence? [Yes] [No]

Do you feel like your bladder, uterus or rectum has fallen? [Yes] [No] Does this affect intercourse? [Yes] [No] Is there tissue at or outside the vaginal opening? [Yes] [No]

How many children do you have? \_\_\_\_\_ How many vaginal deliveries? \_\_\_\_\_ How many C-Sections? \_\_\_\_\_ What difficulties did you have with labor and delivery? \_\_\_\_\_

When was your last period? \_\_\_\_\_ What birth control do you use? \_\_\_\_\_

When was your last PAP? \_\_\_\_\_ Was it normal? [Yes] [No] What was done to treat the abnormality? \_\_\_\_\_

When was your last mammogram? \_\_\_\_\_ Was it normal? [Yes] [No] What was done to treat the abnormality? \_\_\_\_\_

**New Patient Consult**

Date of visit \_\_\_\_\_

**DRUG ALLERGY**

**REACTION**

DRUG ALLERGY	REACTION

**Medical Problems** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Surgeries/Year Performed** \_\_\_\_\_  
\_\_\_\_\_

**Serious medical problems in your family** \_\_\_\_\_  
\_\_\_\_\_

**Social History**

How you ever smoked? \_\_\_\_\_

How often and how much do you drink? \_\_\_\_\_

Marital status? \_\_\_\_\_

Are you sexually active? \_\_\_\_\_ Any problems? \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Are you depressed or do you have a history of depression? \_\_\_\_\_

**Pharmacy:**

**NAME** \_\_\_\_\_ **STREET/CITY/CTATE/ZIP CODE** \_\_\_\_\_

**PHARMACY PHONE NUMBER** \_\_\_\_\_

Name \_\_\_\_\_

Date \_\_\_\_\_



# REVIEW OF SYSTEMS

Have you had any problems related to the following systems in the past 6 months? Circle Yes or No

## General:

Fever	Y	N
Weight change	Y	N
Tire Easily	Y	N
Other _____		
None of these above	___	

## Eyes:

Change in Vision	Y	N
Cataracts	Y	N
Glaucoma	Y	N
Other _____		
None of these above	___	

## Ears, Nose, Throat:

Sores	Y	N
Discharge	Y	N
Pain	Y	N
Other _____		
None of these above	___	

## Respiratory:

Chronic Cough	Y	N
Asthma	Y	N
COPD	Y	N
Other _____		
None of these above	___	

## Cardiovascular:

Shortness of Breath	Y	N
Chest Pain	Y	N
Other _____		
None of these above	___	

## Gastrointestinal:

Nausea/Vomiting	Y	N
Reflux	Y	N
Diarrhea	Y	N
Bloody Stool		
Other _____		
None of these above	___	

## Skin/Breast:

Breast Lumps	Y	N
Skin Rash	Y	N
Other _____		
None of these above	___	

## Musculoskeletal:

Weakness	Y	N
Limited Range of Motion	Y	N
Joint Pain	Y	N
Other _____		
None of these above	___	

## Neurological:

Seizures	Y	N
Burning or Shooting Pain	Y	N
Numbness	Y	N
Other _____		
None of these above	___	

## Hematological:

Easy Bruising	Y	N
Bleeding	Y	N
Swollen Glands	Y	N
Other _____		
None of these above	___	

## Endocrine:

Thyroid Problems	Y	N
Diabetes	Y	N
Other _____		
None of these above	___	

## Psychiatric:

Depression	Y	N
Anxiety	Y	N
Other _____		
None of these above	___	

**Quality of Life**

Date of visit \_\_\_\_\_

**Has urine leakage and or prolapse affected your:**

	None	Slightly	Moderately	Greatly
Ability to do household chores?	0	1	2	3
Physical recreation such as walking?	0	1	2	3
Swimming or exercise?	0	1	2	3
Entertainment activities (movies, concerts, etc.)?	0	1	2	3
Ability to travel by car or bus more than 30 minutes?	0	1	2	3
Participation in social activities outside the home?	0	1	2	3
Emotional health (nervousness, depression, etc)?	0	1	2	3
Feeling frustrated?	0	1	2	3

**Do you experience, and, if so, how much are you bothered by:**

Frequent urination?	0	1	2	3
Urine leakage related to the feeling of urgency?	0	1	2	3
Urine leakage related to physical activity, coughing, or sneezing?	0	1	2	3
Small amounts of urine leakage (drops)?	0	1	2	3
Difficulty emptying your bladder?	0	1	2	3
Pain or discomfort in the lower abdomen or genital area?	0	1	2	3

Name \_\_\_\_\_

Date \_\_\_\_\_


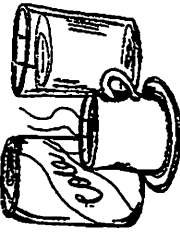
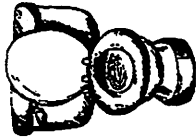






# Your Daily Bladder Diary


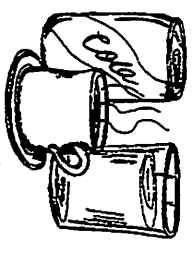
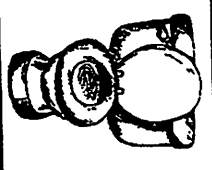




This diary will help you and your health care team. Bladder diaries help show the causes of bladder control trouble. The "sample" line (below) will show you how to use the diary.

Your name: \_\_\_\_\_

Date: \_\_\_\_\_

		ACCIDENTS			
					
Time 	Drinks What kind? How much?	Urine How many times? How much? (circle one)	Accidental leaks How much? (circle one)	Did you feel a strong urge to go? Circle one	What were you doing at the time? Sneezing, exercising, having sex, lifting, etc.
Sample	Coffee 2 cups	✓   sm   med   lg	sm   med   lg	Yes   <b>No</b>	Running
6-7 a.m.				Yes   No	
7-8 a.m.				Yes   No	
8-9 a.m.				Yes   No	
9-10 a.m.				Yes   No	
10-11 a.m.				Yes   No	
11-12 noon				Yes   No	
12-1 p.m.				Yes   No	
1-2 p.m.				Yes   No	
2-3 p.m.				Yes   No	
3-4 p.m.				Yes   No	
4-5 p.m.				Yes   No	
5-6 p.m.				Yes   No	
6-7 p.m.				Yes   No	

**ACCIDENTS**

					
<b>Time</b> 	<b>Drinks</b> What kind? How much?	<b>Urine</b> How many times? How much? (circle one)	<b>Accidental leaks</b> (circle one)	<b>Did you feel a strong urge to go?</b> Circle one	<b>What were you doing at the time?</b> Sneezing, exercising, having sex, lifting, etc.
Sample	Soda 2 cans	✓ <input checked="" type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input checked="" type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input checked="" type="radio"/>	Laughing
7-8 p.m.		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	
8-9 p.m.		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	
9-10 p.m.		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	
10-11 p.m.		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	
11-12 midnight		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	
12-1 a.m.		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	
1-2 a.m.		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	
2-3 a.m.		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	
3-4 a.m.		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	
4-5 a.m.		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	
5-6 a.m.		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	

I used \_\_\_\_\_ pads. I used \_\_\_\_\_ diapers today (write number).

Questions to ask my health care team: \_\_\_\_\_

**ADVANCED PELVIC SURGERY, LLC**  
**R. Gregory Owens, M.D.**

**7162 Liberty Centre Dr.**  
**West Chester, OH 45069**  
**Phone: 513/942-7640**  
**FAX: 513/755-4736**

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- ❖ **CONSENT TO TREATMENT/TESTING:** I hereby consent to the administration of treatment and testing as is considered therapeutically necessary for my condition.
  
- ❖ **RELEASE OF RECORDS:** I authorize the release of medical record information (including, but not limited to information concerning drug related conditions, alcoholism, psychiatric conditions, HIV testing, AIDS diagnosis/related conditions) to insurance carriers, third-party payers or to their representatives, review organizations, or surveyors for accreditation, regulatory and/or licensing purposes, as necessary to determine benefits entitlement and to process payment claims for healthcare services provided. This authorization shall be valid only for the period of time necessary to process payment claims.

In consideration of admission and all facility services, the undersigned agrees to the following:

- ❖ **ASSIGNMENT OF BENEFITS:** I hereby authorize payment directly to Advanced Pelvic Surgery, LLC of all insurance benefits, otherwise payable to me.
  
- ❖ **GUARANTEE OF ACCOUNT:** I unconditionally guarantee the payment in full to the facility of the total amount due them for said admission and/or facility services. I understand that I am financially responsible to the facility and/or physician for the charges not covered by the above assignment. I am also responsible for charges even if determined by my employer or insurance company to be unnecessary in their judgement.
  
- ❖ I have read and do understand this form.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

# WAIVER OF FINANCIAL RESPONSIBILITY

ADVANCED PELVIC SURGERY, LLC  
R. GREGORY OWENS, M.D. F.A.C.O.G.

PATIENT NAME: \_\_\_\_\_

PHYSICIAN NAME: R. Gregory Owens, M.D.

DATE OF SERVICE: \_\_\_\_\_

**I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR SERVICES IN THE EVENT THAT MY INSURER DOES NOT COVER EXPENSES. IF YOU HAVE A DEDUCTIBLE AND IT HAS NOT BEEN MET, PAYMENT FOR SURGERY OR PROCEDURES IN THE OFFICE WILL HAVE TO BE PAID BEFORE SERVICES ARE RENDERED. AN INTEREST CHARGE OF 1 ½ % PER MONTH WILL BE ASSESSED FOR ANY OUTSTANDING PATIENT BALANCE AFTER THE FIRST STATEMENT IS SENT.**

***TO ASSIST YOU WITH YOUR MEDICAL CARE, WE PROVIDE THE FOLLOWING PAYMENT OPTIONS:***

- 1. CASH – INCLUDES PERSONAL CHECKS**
- 2. VISA, MASTERCARD, DISCOVER, DINERS CLUB, JBC, AMEX**
- 3. CareCredit – Patient payment plans that allow you to pay over time with convenient low minimum payments. With CareCredit, you enjoy these benefits:**
  - **Flexible Financing options**
  - **No annual fees or prepayment penalties**
  - **Quick and easy application**
  - **Receive a credit decision almost immediately**
  - **Start your recommended treatment immediately**

SIGNATURE: \_\_\_\_\_

RELATIONSHIP IF OTHER THAN PATIENT: \_\_\_\_\_

DATE: \_\_\_\_\_

**CONSENT TO DISCUSS**

I, \_\_\_\_\_, give my consent to Advanced Pelvic  
Surgery to discuss my medical condition with \_\_\_\_\_.  
**Family Member or Friend**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date