Lifeline Medical Associates
Transforming Women's Healthcare

Center for Urogynecology and Reconstructive Pelvic Surgery
MANISH GOPAL MD, MSCE

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 Urogynecolgical 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 202, Monroe, New Jersey 08831
901 West Main Street, Donna O'Donnell Medical Arts Building Freehold NJ 07728
1 Route 70 West, Lakewood , New Jersey 08701

You can reach our office Monday through Friday 8:30 am to pm at 877-987-6496

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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.

CENTER FOR UROGYNECOLOGY AND RECONSTRUCTIVE PELVIC SURGERY

Manish Gopal, MD, MSCE

Division Director

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.

Pelvic Floor Muscle Rehab (PFMR) Therapy for Urinary Incontinence continued:

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.

Center forUrogynecology and Reconstructive Pelvic Surgery

Manish Gopal M.D.MSCE

PLEASE PRINT CLEARLY AND COMPLETE ALL AREAS

Last Name: ____ First Name: __________________________________ Mid: ________

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

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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**

Center for Urogynecology and Reconstructive Pelvic Surgery

PAST MEDICAL HISTORY FORM

NAME:____ BIRTH DATE:____/____/_____ DATE:____/____/____

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

Weight loss ❑ CURRENTLY ❑ PAST NOTES
Weight gain ❑ CURRENTLY ❑ PAST NOTES
Fever ❑ CURRENTLY ❑ PAST NOTES
Fatigue ❑ CURRENTLY ❑ PAST NOTES

Double vision ❑ CURRENTLY ❑ PAST NOTES
Spots before eyes ❑ CURRENTLY ❑ PAST NOTES
Vision changes ❑ CURRENTLY ❑ PAST NOTES

Ear aches ❑ CURRENTLY ❑ PAST NOTES
Ringing in ears ❑ CURRENTLY ❑ PAST NOTES
Sinus problems ❑ CURRENTLY ❑ PAST NOTES
Sore throat ❑ CURRENTLY ❑ PAST NOTES
Mouth sores ❑ CURRENTLY ❑ PAST NOTES
Dental problems ❑ CURRENTLY ❑ PAST NOTES

Painful breathing ❑ CURRENTLY ❑ PAST NOTES
Chest pain ❑ CURRENTLY ❑ PAST NOTES
Difficult breathing:
On exertion ❑ CURRENTLY ❑ PAST NOTES
Swelling of legs ❑ CURRENTLY ❑ PAST NOTES
Palpitations of heart ❑ CURRENTLY ❑ PAST NOTES

Wheezing ❑ CURRENTLY ❑ PAST NOTES
Spitting up blood ❑ CURRENTLY ❑ PAST NOTES
Shortness of breath ❑ CURRENTLY ❑ PAST NOTES
Cough, chronic ❑ CURRENTLY ❑ PAST NOTES

Diarrhea, frequent ❑ CURRENTLY ❑ PAST NOTES
Bloody stool ❑ CURRENTLY ❑ PAST NOTES
Nausea/vomiting ❑ CURRENTLY ❑ PAST NOTES
Constipation ❑ CURRENTLY ❑ PAST NOTES

Blood in urine ❑ CURRENTLY ❑ PAST NOTES
Pain with urination ❑ CURRENTLY ❑ PAST NOTES
Urgency ❑ CURRENTLY ❑ PAST NOTES
Frequency of urination ❑ CURRENTLY ❑ PAST NOTES
Incomplete emptying ❑ CURRENTLY ❑ PAST NOTES
Stress incontinence ❑ CURRENTLY ❑ PAST NOTES
Abnormal periods ❑ CURRENTLY ❑ PAST NOTES
Painful intercourse ❑ CURRENTLY ❑ PAST NOTES

Page 2 PAST MEDICAL HISTORY FORM NAME:______________________________ BIRTH DATE:____/____/_____

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

Muscle weakness ❑ CURRENTLY ❑ PAST NOTES

Pain in breast ❑ CURRENTLY ❑ PAST NOTES
Nipple Discharge ❑ CURRENTLY ❑ PAST NOTES
Masses/Lumps ❑ CURRENTLY ❑ PAST NOTES
Rashes ❑ CURRENTLY ❑ PAST NOTES
Ulcers ❑ CURRENTLY ❑ PAST NOTES

Dizziness ❑ CURRENTLY ❑ PAST NOTES
Seizures ❑ CURRENTLY ❑ PAST NOTES
Numbness ❑ CURRENTLY ❑ PAST NOTES
Trouble walking ❑ CURRENTLY ❑ PAST NOTES

Depression ❑ CURRENTLY ❑ PAST NOTES
Crying, frequent ❑ CURRENTLY ❑ PAST NOTES

Dry skin ❑ CURRENTLY ❑ PAST NOTES
Abnormal thirst ❑ CURRENTLY ❑ PAST NOTES
Hot flashes ❑ CURRENTLY ❑ PAST NOTES

Bruises, frequent ❑ CURRENTLY ❑ PAST NOTES
Cuts do not stop bleeding ❑ CURRENTLY ❑ PAST NOTES
Enlarged lymph nodes ❑ CURRENTLY ❑ PAST NOTES

Allergies ❑ CURRENTLY ❑ PAST NOTES
Drugs, other ❑ CURRENTLY ❑ PAST NOTES

MAJOR ILLNESSES YES NO MAJOR ILLNESSES YES NO

Asthma Cancer ❑YES ❑NO
Pneumonia Ulcers ❑YES ❑NO
Chronic Lung Disease Depression/anxiety ❑YES ❑NO
Kidney Infections/stones Anemia/Blood transfusions ❑YES ❑NO

Tuberculosis Seizures/convulsions/epilepsy ❑YES ❑NO
Venereal Disease Bowel trouble ❑YES ❑NO
Heart Trouble/murmur Glaucoma ❑YES ❑NO
Diabetes Arthritis/joint pain ❑YES ❑NO
High Blood Pressure Fracture ❑YES ❑NO
Stroke Hepatitis/Yellow jaundice ❑YES ❑NO
Rheumatic Fever Thyroid Disease ❑YES ❑NO

Other Explain: ____

____

____

Page 3 PAST MEDICAL HISTORY FORM NAME:______________________________ BIRTH DATE:____/____/_____

OPERATIONS/HOSPITALIZATIONS

Reason	Date	Reason	Date

INJURIES/ILLNESSES

Type	Date	Type	Date

LAST IMMUNIZATION OR TEST

Type	Date				Type	Date
Flu Shot					TB Skin Test	
Pneumonia					Tetanus	
Other:						

OB/GYN HISTORY

	Number				Type	Number
Births					Abortions	
Miscarriages					Living Children	

CURRENT MEDICATIONS

Drug Name	Dosage	Drug Name	Dosage

Page 3 PAST MEDICAL HISTORY FORM NAME:______________________________ BIRTH DATE:____/____/_____

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:_______________