AIAVS
ALINSOD INSTITUTE
for AESTHETIC VULVOVAGINAL SURGERY

INITIAL HISTORY AND PHYSICAL **Date:**_____

Patient Name_____ **Medical Record #**_____
Age_____ **Date of Birth** _____
Pregnancies_____ **Births**____**(Vaginal** ____**Cesarean**____**)** **Miscarriages**____ **Abortions**____
Address: _____
_____
_____

Phone (Home) _____ **Allergies**: ☐None
Phone (Work) _____ ☐Yes_____
Phone (Cell) _____ _____
Phone (Fax) _____ _____
Email _____

Referring Physician: _____
Primary Care Physician: _____

How did you hear about us? _____

CHIEF COMPLAINT (Why you want to see the doctor today?)
_____
_____
_____
_____
_____
_____
_____

AESTHETIC VULVOVAGINAL SURGERY QUESTIONAIRE

☐ **Skip this section. I have no problems with aesthetics or function of my vaginal area.**

_____ I want aesthetic vaginal surgery
_____ My labia are larger than what I want
_____ I do not like the way my labia looks
_____ My labia rub, tug, and pull on my clothing
_____ I am unable to wear the type of clothing I want
_____ I have had unflattering comments about my genital region

_____ I have had difficult births
_____ My vagina feels too loose
_____ I have decreased sensations
_____ I feel pelvic heaviness and pressure
_____ I rely on my appearance at work
_____ Sex is uncomfortable or unpleasant
_____ Orgasms are difficult to achieve or weak

INTERESTED IN NON-SURGICAL TREATMENTS

☐ To tighten the labia majora or puff it up
☐ To tighten the vagina
☐ To treat a leaky bladder
☐ To reduce urinary urgency and frequency
☐ To improve vulvar and vaginal moisture
☐ To improve sensitivity of tissues
☐ To improve or achieve orgasms
☐ Reduce painful intercourse

INTERESTED IN AESTHETIC LASERS/IPL/RADIOFREQUENCY TREATMENTS

☐ I want Vulvar Lightening
☐ I want to remove brown spots/sun damage
☐ I want to remove red blood vessels
☐ I want microneedling or FotoFacial
☐ I want Hair reduction/Brazillian
☐ I want Skin Tightening
☐ I want Botox/Skin Fillers
☐ I want Stretch Marks/Scar Reduction
☐ I want Collagen/Vitamin C Facials
☐ I want info on Skin Care Products

Patient Name_____

BLADDER SYMPTOM QUESTIONNAIRE

☐ **Skip this section. I have no bladder/kidney or urinary problems.**

How often do you urinate: during the **day**? _____Times
during the **night**? _____Times

Do you leak urine (incontinence)?	Yes No
Duration of incontinence? _____Months _____ Years	
Is it caused by **coughing, laughing, sneezing, running, sports**, etc.?	Yes No
Is the amount of urine you usually pass	Large Average Small
Do you have difficulty starting your urinary flow?	Yes No
Do you strain to void your urine?	Yes No
Do you feel that you empty your bladder completely?	Yes No
Do you notice dribbling of urine after voiding?	Yes No
Do you have to assume abnormal positions to urinate?	Yes No
Do you need to wear protective 'pads' for this type of incontinence?	Yes No
Are you bothered by a **strong sense of urgency** to void?	Yes No
Can you overcome the sensation of urgency to void?	Yes No
Do you sometimes not make it to the bathroom in time (urgency?)	Yes No
What activities seem to cause you to loose control of your urine?	
- sight, sound or feel of running water	Yes No
- standing up after being seated or lying down	Yes No
- "key in the door" when you return home	Yes No
Do you lose your urine during intercourse?	Yes No
if yes - with deep penetration	Yes No
- with orgasm?	Yes No
Do you lose urine without any warning (without activity or urgency)	Yes No
When urinating, can you usually stop your stream?	Yes No
Do you ever wet the bed while asleep?	Yes No
Would you describe the amount of urine that you leak as being (you may answer more than one)	
- frequent small volumes……	Yes No
- unconscious/continuous loss (always damp or wet)	Yes No
- infrequent but single large volumes of loss …….	Yes No

Is your urine flow: (circle one) Strong Weak Dribbling Intermittent

How many pads do you usually use per day for protection? (circle) 1, 2, 3, 4, 5, 6, 7, 8, more.

Has urine leakage limited your ability to:	not at all | min | mild | mod | greatly
- do household chores (cooking, house-cleaning, laundry)?	0 1 2 3 4
- recreation such as walking, swimming, or other exercise?	0 1 2 3 4
- participate in activities (church, movies, concerts)?	0 1 2 3 4
- travel more than 30 minutes from home?	0 1 2 3 4
- participate in social activities outside your home?	0 1 2 3 4
- participate in, enjoy, or feel comfortable with sexual activity?	0 1 2 3 4
Do you have reduced self-esteem, depression, frustration, nervousness?	Yes No
Do you have frequent urinary infections?	Yes No
How often have these occurred in recent years? 1, 2, 3, 4 or more per year. (circle choice)	
Do you ever see blood in your urine?	Yes No
Do you have pain during urination?	Yes No
Do you have pain in the lower abdomen?	Yes No
Is the pain related to:	
- your bladder being full?	Yes No
- your menstrual cycle?	Yes No
- intercourse?	Yes No
- bowel movements?	Yes No

Patient Name_____

GYNECOLOGIC QUESTIONNAIRE

Do you have menstrual periods? _____Yes _____No (skip to PAP Questions below)
Date of last menstrual period:_____
If you have periods, are they: **regular / irregular, heavy / moderate / scant / painful**? Circle
If Irregular periods, for how long? _____Months _____Years
If you have painful periods, does the pain occur **before** or **during** or **after** menses? Circle
If painful periods, for how long? _____Months _____Years
If you no longer have menstrual periods:

Hysterectomy:	Yes No
Surgical removal of your ovaries?	Yes No

When was your last PAP smear? _____ Normal / Abnormal. Circle

Have you had treatments for abnormal PAPs?	Yes No
If yes, please explain: _____	
Are you having any abnormal vaginal discharge or discomfort?	Yes No
Do you have a feeling of vaginal fullness or pressure?	Yes No
Can you see or feel a swelling protruding from the vagina?	Yes No
Do you push the protrusion back to have a BM or empty your bladder?	Yes No
Are you sexually active?	Yes No
Are your partner(s): Men_____ Women_____ Both_____	
Do you have any sexuality concerns to discuss with us?	Yes No
If yes, please explain:_____	

Birth Control:

Do you have a need for birth control?	Yes No
Are you or your partner using any birth control now?	Yes No
If yes, what method?_____ ___	
Are you satisfied with this method?	Yes No
Have you ever had a sexually transmitted disease?	Yes No
If yes, please explain:_____	
Do you have recurrent bladder infections?	Yes No
If yes, (1) Please explain: _____	
(2) Have you had kidney infection(s)?	Yes No

Hormone Questionnaire:

Do you take (or have you ever taken hormone replacement?	Yes No
Are you interest in Bio-Identical Hormone Replacement Therapy?	Yes No
Are you experiencing any of the following symptoms?	
Hot flashes	Yes No
Night Sweats	Yes No
Sleep Disturbance	Yes No
Loss of Libido/Sexual Desire	Yes No
Vaginal Dryness	Yes No
Fatigue and tiredness	Yes No
Mood Swings and Irritability	Yes No
Anxiety and Muscle Tension	Yes No
Forgetfulness	Yes No
Hair Loss	Yes No
Skin Disorders	Yes No

Patient Name_____

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS (other current health problems):

☐ **Skip this section. I am completely healthy without any conditions mentioned below.**

Are you physically active? Yes No What type of exercise? _____

Describe_____

Do you now have or have you ever had:

Neurologic (seizures, headaches, weakness, paralysis) problems? Yes No _____

Psychiatric problems? Depression? Mania? Bipolar? Yes No _____

Head/Ear/Eyes/Nose/Throat Problems? Yes No _____

Thyroid problems? Yes No _____

Cardiac (heart) problems? Palpitations? Chest Pain? Irregular Beat? Yes No _____

Lung Problems? Asthma? Short of Breath? Yes No _____

Breast Problem? Mass? Lumpiness? Discharge? Pain? Yes No _____

Gastrointestinal (stomach) problems? Yes No _____

Kidney or bladder disease? Stones? Infections? Yes No _____

Liver problems? Yes No _____

Hematologic (bleeding, anemia) bleeding problems? Yes No _____

Diabetes (insulin dependent/oral medication) Yes No _____

Musculoskeletal (bones, joints, muscles) problems? Yes No _____

Circulation problems (varicose veins, thrombosis)? Yes No _____

Cancer Yes No Type _____

High Blood Pressure Yes No _____

OtherProblems_____

_____

PAST SURGERIES OR HOSPITALIZATIONS

☐**NONE**

Please list with date:

_____

_____

_____

_____

_____

FAMILY HISTORY (check illness which has occurred in any blood relative and write relationship to you):

____ Cancer (type and In whom) _____

____ Bleeding Disorder _____

____ Heart disease _____

____ Diabetes _____

____ Others _____

_____

SOCIAL HISTORY

Marital status: S M W D Separated

Occupation ☐Not Working ☐Working: What Occupation?_____

Tobacco use: Yes No Daily amount _____Number of years_____

Alcohol use: Yes No Daily amount _____

Drug use Yes No Daily amount _____Which Drugs? _____

Caffeine Use: Yes No Daily amount _____

Abuse Yes No Describe_____

Other: _____

_____

_____

_____

Patient Name_____

MEDICATION HISTORY
☐**NONE**
Please list all current medications and dosages

☐VITAMINS ☐FISH OIL ☐MOTRIN/ADVIL/ALLEVE/ASPIRIN

_____
_____
_____
_____
_____
_____

ALLERGIES:
☐**NONE**: No known allergies (**NKA**)
☐LIST ALLERGIES AND TYPE OF REACTION BELOW

_____
_____
_____

REVIEW OF SYSEMS: **LAST MAMOGRAM**_____ **Last LIPID PANEL**_____
LAST COLONOSCOPY_____ **Last FASTING SUGAR**_____
LAST BONE SCAN_____ **Last HgA1C**_____

PUF QUESTIONAIRE SCORE_____**Date**_____

NOTES:

Patient Name_____

EXAMINATION: Date of Exam_____

Constitutional: Ht_____ Wt_____
Temp_____ BP _____ Pulse _____ Respiration _____

	Normal	**Abnormal**		
Appearance:	[ ]	[ ]	_____	
HEENT:	[ ]	[ ]	____No thyromegaly ____Throat clear	
Heart:	[ ]	[ ]	____No murmurs ____No heaves ____No gallops ____No irregularities	____Murmur ____Irregular Rhythm
Lungs:	[ ]	[ ]	____Clear ____No Rales ____No Wheeze	____Congested Sounding ____Rales ____Wheeze
Breast/Chest:	[ ]	[ ]	____No Mass ____No Discharge ____Lymp Node Survey Normal	____Fibrocystic Changes ____Abnormal Discharge ____Abnormal Nodes
Abdomen:	[ ]	[ ]	____Soft ____No Masses ____Non-Tender ____Bowel Sounds Normal	____Scars ____Mass Palpated ____Tender
Extremities:	[ ]	[ ]	____No Cyanosis ____No Clubbing ____No Edema ____No Malformations	

Skin Lesions ☐None _____
Lymph Nodes ☐Normal _____
Hernias ☐None _____

Other
_____
_____
_____
_____
_____

Drawing:

Patient Name_____

UROGYNECOLOGIC EXAM: **DATE of EXAM**:_____

Introitus:		Normal	Virginal	Stenotic	Parous
Estrogenization		Normal	Atrophic		
Neurologic:	Clitoral Reflex:	Normal	Decreased	Absent	
	Anal wink:	Normal	Decreased	Absent	
Perineal Body:		Normal	Shortened	Bulging	
Vulvar/Perineal/Vaginal		Normal	Labial Enlargement		Labial Asymmetry
Urethra: Appearance		Normal	_____		
Urethral Hypermobility:		None	0, +, ++, +++		

Stress Test:	Upright	Negative	Positive	
	Standing	Negative	Positive	
Empty Bladder Stress Test		Negative	Positive	
Urethral Hypermobility		Negative	Positive	
Q-Tip Test:		Negative	Positive_____	Degrees
Spontaneous Cough Strain Volume:		+, ++, +++		

BLADDER SCAN: _____

Vagina Pelvic Floor Musculature: Tone: Good Fair Poor
Cystocele: (lateral / central / combined defect) Stage 0, 1, 2, 3, 4
Rectocele: (distal / proximal) Stage 0, 1, 2, 3, 4
Enterocele: Stage 0, 1, 2, 3, 4
Vaginal cuff prolapse Stage 0, 1, 2, 3, 4
Vaginal Length: ____normal ____shortened ____deep
Vaginal Lesions:_____
Tenderness: (none / cuff / levator / bladder / introital/ uterus)
Uterus Present _____ Absent _____
Size (normal / enlarged / atrophic) _____week size
Prolapse Stage 0, 1, 2, 3, 4
Describe _____
Adnexa Masses: ____None
Right _____
Left _____
Andexal Tenderness ____None
Right _____
Left _____
Rectal Exam: ____Normal
____No Mass ____Mass Palpated
Rectal Tone: ____Normal ____Abnormal
AnalTags: ____None ____External ____Internal

☐Vaginal Laxity_____ ____Gaping Introitis
☐Enlarged/Loose ____Labia Minora ____Labia Majora ____Majora Deflation
☐Asymetric Labia Minora
☐Excess Clitoral Hood

Pelvic Organ Prolapse Assessment

Drawing

O Anal Skin Tags # ____

Patient Name_____

IMPRESSION:

_____Normal & Healthy Annual Examination
_____Requests Contraception
_____Peri-menopause/Menopause ____Requests Hormones
_____GSM/Atrophy/Dyspareunia
_____SUI (Stress Incontinence)
_____ISD (Instrinsic Sphincter Defficiency)
_____DO (Detrussor Over Activity)
_____OAB Wet Dry
_____IC
_____Overflow Incontinence
_____Mixed Incontinence
_____Cystocele Grade 0 1 2 3 4
_____Rectocele Grade 0 1 2 3 4
_____Enterocele Grade 0 1 2 3 4
_____Uterine Prolapse Grade 0 1 2 3 4
_____Vaginal Prolapse Grade 0 1 2 3 4
_____Labial Hypertrophy/Asymmetry ☐Labial Discomfort
_____Wide or redundant Clitoral Hood ☐Multiple Folds
_____Vaginal Laxity
_____Gaping Introitus
_____Anal Skin Tags # ____
_____IC

OTHER_____
OTHER_____
OTHER_____
OTHER_____
OTHER_____
OTHER_____

PLAN & RECOMMENDATIONS:

☐PAP	☐Lipids	☐Hormone Panel	☐CBC	☐UA + C&S ☐PCR
☐Mammo	☐FBS	☐Thyroid Panel	☐Chem Panel	☐Pregnancy Test
☐GC/Chlam	☐HGA1C	☐Vag Culture	☐Wet Mount	☐Bio HRT Pellets

☐SLING/CYST	☐LUKSENBUR	☐VAGINOPLASTY	☐WING LIFT	☐AST Removal#_____
☐ANT REP	☐NATIVE	☐PERINEOPLASTY	☐BLAD BOTOX	☐PRP/O-SHOT
☐POST REP	☐BIOLOGIC	☐LABIA MAJ PLASTY	☐BARBIE	☐FEMXHA
☐SSLS	☐MESH	☐LABIA MIN PLASTY	☐HYBRID	☐THERMIVA/MORPH/EMFM
☐UTER SUSP	☐NATIVE TISS	☐CLIT HOOD REDUC	☐RIM	☐MLT/DIVA_____

☐TRIPLE HU CREAM E2_____ E3_____ P_____ T_____ DHEA_____

☐ARMOR THYROID _____GR/MG ☐DIM ☐VIT ☐FISH OIL

_____
_____
_____
_____
_____
_____
_____
_____
_____

☐RISKS/BENEFITS/OPTIONS DISCUSSED WITH PATIENT AT LENGTH

CONSULTATIONS SCHEDULED:

Pre-Op With_____
Anesthesia_____

FOLLOW UP ____**Days** ____**Weeks** ____**Months** ____**Year/s**

SIGNATURE _____

DATE _____

REVIEWED _____

NO CHANGES _____

CHANGES _____

_____

QUALITY OF LIFE & SYMPTOMS DISTRESS INVENTORY

NAME_____DATE_____

Please answer each question by checking the best response
Between 0 (not at all) and 3 (greatly).
Incontinence impact questionnaire

Has urinary leakage and/or prolapsed affected your:	0= not at all	1= slightly	2= moderately	3= greatly	
1. Ability to do household chores (cooking, housecleaning, laundry)?					PA
2. Physical recreation such as walking, swimming, or other exercise?					PA
3. Entertainment activities (movies, concerts, etc.)?					T
4. Ability to travel by car or bus more than 30 minutes from home?					T
5. Participation in social activities outside your home?					SR
6. Emotional health (nervousness, depression, etc.)?					EH
7. Feeling frustrated?					EH

Urogenital distress inventory

Do you experience, and, if so, how much are you bothered by:	0= not at all	1= slightly	2= moderately	3= greatly	
1. Frequent urination?					I
2. Urine leakage related to the feeling of urgency?					I
3. Urine leakage related to physical activity, coughing, or sneezing?					S
4. Small amounts of urine leakage (drops)?					S
5. Difficulty emptying your bladder?					OD
6. Pain or discomfort in the lower abdominal or genital area?					OD
7. A feeling of bulging or protrusion in the vaginal area?					OD
8. Bulging or protrusion you can see in the vaginal area?					OD

PA=physical activity; T=travel; SR=social/relationships; EH=emotional health;
OD=obstructive/discomfort symptoms; I=irritative symptoms; s=stress symptoms

NAME_____DATE_____

The Pelvic Pain and Urinary/Frequency (PUF) Patient Symptom Scale

	0	1	2	3	4	Symptom Score	Bother Score
1. How many times do you go to the bathroom during the day?	3-6	7-10	11-14	15-19	20+		
2a. How many times do you go to the bathroom at night?	0	1	2	3	4+		
2b. If you get up at night to go to the bathroom, does it bother you?	Never	Midly	Moderate	Severe			
3. Are you currently sexually active? Yes_____ No _____							
4a. If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occassionally	Usually	Always			
4b. If you have pain, does it make you avoid sexual intercourse?	Never	Occassionally	Usually	Always			
5. Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes, or scrotum)?	Never	Occassionall	Usually	Always			
6. Do you have urgency after going to the bathroom?	Never	Occassionally	Usually	Always			
7a. If you have pain, is it usually…		Mild	Moderate	Severe			
7b. Does your pain bother you?	Never	Occassionally	Usually	Always			
8a. If you have urgency, is it usually…		Mild	Moderate	Severe			
8b. Does your pain urgency bother you?	Never	Occassionally	Usually	Always			
					Symptom Score (1, 2a, 4a, 5, 6, 7a, Bal =		
					Bother Score (2b, 4b, 7b, 8b) =		
					Total Score (Symptom Score + Bother Score) =		

Please circle the answer that best describes how you feel for each question.

Family History Questionnaire for Common Hereditary Cancer Syndromes

Please mark below if there is a ***personal or family history*** of any of the following cancers. If yes, then indicate family relationship and ***age at diagnosis*** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	SIBLINGS/ CHILDREN	MOTHER'S SIDE	FATHER'S SIDE
For example: Colorectal cancer		*Brother 36 yrs.*	*Aunt 44 yrs Cousin 58 yrs*	*Grandfather 65 yrs*
BREAST AND OVARIAN CANCER				
Breast cancer				
Ovarian cancer				
Breast cancer in both breasts OR multiple primary breast cancers				
Male breast cancer				
Are you of Ashkenazi Jewish discent?				
COLON AND UTERINE CANCER				
Uterine (endometrial) cancer				
Colorectal cancer				
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer				
10 or more cumulative colon polyps				
MELANOMA				
Melanoma				
Pancreatic cancer				
OTHER CANCER				

NAME_____DATE_____

INTAKE & VOIDING DIARY

This chart is a record of your fluid intake, voiding and urine leakage.
Choose 4 days (entire 24 hours) to complete this record – they DO NOT have to be in a row.
Pick days in which will be convenient for you to measure EVERY void.
Please bring this diary to your next visit.

INSTRUCTIONS:
1. Begin recording upon rising in the morning-continue for a full 24 hours.
2. Record separate times for voids, leaks and fluid intake.
3. Measure voids in "cc's" using the hat.
4. Measure fluid intake in ounces.
5. When recording a leak – please indicate the volume ("1,2, or 3"), your activity during the leak, and if you had an urge ("yes" or "no")

Example of entries

DATE:

TIME	**Amount voided** (in ccs)	**LEAK Volume** 1=drops/damp 2=wet-soaked 3=bladder emptied	**Activity during leak**	**Was there an urge?**	**Fluid intake** (Amount in ounces/type)
7:00a	*250cc*	*2*	*Running*	*Yes*	
7:30a					*8 oz./Herbal tea*