CLIENT INTAKE SHEET – TRANSVAGINAL MESH IMPLANTS

Date Mesh Implant Was Implanted: _____

Date Mesh Implant Was Removed or Repaired (if applicable): _____

PERSONAL INFORMATION

Client: _____

Address: _____

_____

_____

_____

E-Mail: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

DOB: _____ Age: _____

SSN: _____

M/F: _____

Minor: Y N

Married: Y N

Spouse Name: _____

Spouse SSN: _____

Next Relative: _____

Address: _____

MESH IMPLANT INFORMATION

Which Mesh Implant Did You Receive: _____

Who was the manufacturer of your mesh implant:

C.R. Bard

American Medical Systems

Boston Scientific

Sofradium

Ethicon

Unknown

Johnson & Johnson

Mentor Corporation

Caldera

Tyco

Other: _____

What Facility Was Mesh Implanted At: _____

Address: _____

_____

Name of Doctor That Implanted Mesh: _____

Name of Doctor's Office or Practice: _____

Address: _____

_____

Dates of Mesh Implant _____

Do you know the size of your implanted mesh? _____

Have you developed: Pelvic organ prolapse (POP)? Yes No

Stress urinary incontinence (SUI)? Yes No

Erosion of the vaginal tissue? Yes No

Infection? Yes No

Bleeding? Yes No

Pain? Yes No

Urinary problems such as incontinence? Yes No

Pain during sexual intercourse (dyspareunia) ? Yes No

Organ perforation (puncturing) from surgical tools during mesh implantation? Yes No

Have you ever had any other mesh implants in the past? Yes No

Date of procedure or symptoms:_____

MESH IMPLANT MEDICAL TREATMENT and INFORMATION

Transported by Ambulance: Y N Name of Ambulance Company: _____

Hospital: Admitted: Y N

1. Hospital: Dates of Treatment: _____

Name: _____

Address: _____

_____

2. Other Hospitals: Dates of Treatment: _____

Name: _____

Address: _____

_____

3. GYN: Dates of Treatment: _____

Name: _____

Address: _____

_____

4. Mesh Implant Surgeon: Dates of Treatment: _____

Name: _____

Address: _____

_____

5. Medical Providers: Dates of Treatment: _____

Name: _____

Address: _____

_____

6. Medical Providers: Dates of Treatment: _____

Name: _____

Address: _____

_____

7. Medical Providers: Dates of Treatment: _____

Name: _____

Address: _____

_____