

Patient Name: _____

Date: _____

Age: _____ Medical Doctor and office location: _____

Gynecologist and location: _____

Drug allergies: _____

Your Pharmacy: _____ Pharmacy phone #: _____

The bladder, gynecological and/or rectal problems bothering you the most are (please number in order of what bothers you the most):

- Urine leakage with exertion, cough or sneeze
- Feeling of bulge in vaginal area
- Urine leakage with urgency, before reaching the bathroom
- Urinary frequency or urgency
- Recurrent urine infections
- Blood in the urine
- Trouble urinating
- Trouble evacuating stool or constipation
- Fecal incontinence
- Pain with intercourse
- Pelvic pain
- Other _____

If you have incontinence of urine or feces (circle which), how often do accidents occur? _____

Previous Treatments? (Circle all that apply.): surgery biofeedback pessary medications

OBSTETRICAL & GYNECOLOGICAL HISTORY

Number of pregnancies: _____ Number Full-term: _____ Number Pre-term (over 20 weeks): _____

Number of vaginal deliveries _____ Episiotomy or Laceration? Yes No Don't know

Weight of largest baby _____ Reason for Cesarean section (if applicable): _____

Date of Last menstrual period: _____

Are you taking Estrogen? Yes No If "yes," Orally or Vaginally? Since what year? _____

SURGICAL HISTORY (Please check which surgeries you have had: Gyn or otherwise):

- NONE
- Hysterectomy No Yes _____ (Year) Incision or Laparoscopic or Vaginal
- Removal of ovaries No Yes _____ (Year) Incision or Laparoscopic
- Laparoscopy Pelvis No Yes _____ (Year) *What was done?* _____
- Prolapse Surgeries No Yes _____ (Year) Incision or Vaginal *Type:* _____
 _____ (Year) Incision or Vaginal *Type:* _____
 _____ (Year) Incision or Vaginal *Type:* _____
- Incontinence Surgery No Yes _____ (Year) Incision or Vaginal *Type:* _____
- Appendix No Yes _____ (Year) Incision or Laparoscopic
- Gallbladder No Yes _____ (Year) Incision or Laparoscopic
- Hernia Repair No Yes _____ (Year) Incision or Laparoscopic
- Bowel Surgery No Yes _____ (Year) *Type:* _____
- Hemorrhoids No Yes _____ (Year)

SURGICAL HISTORY (CONTINUED)

Back Surgery (where in spine) _____

Surgery for cancer of any kind _____

Other Procedure _____ (Year) _____

Other Procedure _____ (Year) _____

MEDICAL HISTORY**Cardiac**

High Blood Pressure Yes No
 Heart Attack Yes No
 Heart Murmur Yes No
 Irregular Heartbeat Yes No
 Mitral Valve Prolapse Yes No
 Peripheral Vascular D Yes No
 High cholesterol Yes No

Respiratory

Asthma Yes No
 Chronic Cough Yes No
 Bronchitis Yes No
 Emphysema Yes No

Gastrointestinal

Ulcers Yes No
 Irritable Bowel Yes No
 Constipation Yes No
 Diverticulitis Yes No
 Ulcerative colitis/
 Crohn's Disease Yes No

GenitoUrinary

Recurrent Urine Infections Yes No
 Recurrent Vaginal infections Yes No
 History of Venereal Disease Yes No
 Kidney infection Yes No
 Kidney Stones Yes No
 Problems with anesthesia Yes No

Other: _____

Endocrine

Diabetes Yes No
 Thyroid Yes No
 Osteoporosis Yes No
 Arthritis Yes No
 Steroid Use Yes No
 Lupus Yes No

Neurologic

Spine/ Back Injury Yes No
 Multiple Sclerosis Yes No
 Parkinson's Yes No
 Stroke Yes No
 Seizure Disorder Yes No

Bleeding Disorder

Aspirin Use Yes No
 History of Blood Clot Yes No
 Platelet Problem Yes No
 Blood Transfusion Yes No

Cancer

Breast Cancer Yes No
 Ovarian cancer Yes No
 Uterine cancer Yes No
 Cervical cancer Yes No
 Colon cancer Yes No
 Other cancer Yes No

MEDICATIONS (Please list individually with dosages.):

FAMILY HISTORY

Have any of your family members ever had any of the following: (Check the appropriate box.)

- | | | | |
|---------------------|--------------------------|----------------------------|--------------------------|
| High Blood Pressure | <input type="checkbox"/> | Bleeding Disorder | <input type="checkbox"/> |
| Heart Problems | <input type="checkbox"/> | Inflammatory Bowel Disease | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | Prolapse | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Urinary Incontinence | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Hernia Repair | <input type="checkbox"/> |
| Kidney Disease | <input type="checkbox"/> | Clotting Disorder | <input type="checkbox"/> |

SOCIAL HISTORY

- Do you live alone? Yes No
- Do you smoke? Yes No How many cigarettes/day? _____
- Do you use alcohol? None Occasionally Daily More
- Do you consume caffeine? None Occasionally Daily More
- Do you use illegal drugs? None Occasionally Daily
- Do you exercise? Yes No Type of exercise: _____
- Are you currently employed? Yes No
- Type of work: _____

GROUP I (SUI)

- Do you lose urine during coughing, sneezing, laughing, or lifting? Yes No Unsure
- When the urine comes out, does it stop when the cough or sneeze is over? Yes No Unsure
- Do you have good control of urine if you are not coughing, sneezing, laughing, lifting or straining? Yes No Unsure
- When the urine leaks, does it stop quickly or continue to drip? Yes No Unsure

GROUP II (OAB with leak)

- Do you ever have an uncomfortably strong need to urinate? Yes No
- If you answered "yes" to the previous question, do you ever leak urine on the way to the toilet? Yes No
- Does the sight, sound or feel of running water cause you to lose urine? Yes No
- Have you wet the bed in the last year? Yes No
- Does urine leak without an apparent cause (no lifting/straining)? Yes No

GROUP III (OAB)

1. How many times do you urinate during the night, after going to bed? _____
2. How often do you need to urinate during the day?
 every 1 hour or less every 2 hours every 3 – 4 hours > 5 hours
3. How much urine can your bladder hold compared to others?
 hardly anything small amount moderate amount I am a camel
4. How long can you hold your urine if you have to?
 less than one hour 2 hours 3 – 4 hours > 5 hours

GROUP IV (bowel symptoms)

1. Do you have constipation? Yes No
2. Do you have trouble evacuating the rectum even if stools are soft? Yes No
3. Do you need to use finger to evacuate rectum? Yes No
4. Do you have fecal urgency? Yes No
5. Do you have fecal leakage? Yes No
6. Do you have inability to control gas? Yes No
7. Do you take any laxatives/stool softeners/fiber regularly? Yes No
8. Do you have any blood in your stool or black tarry stools Yes No

GROUP V (prolapse symptoms)

1. Are you aware of any bulges in the vagina or of something falling or protruding? Yes No
2. If you answered “yes” to the previous question, how much does this bother you?
 Aware of it Worried Mildly uncomfortable Moderately uncomfortable Very uncomfortable
3. Does the bulge seem to get in the way for urination or bowel movements? Yes No
4. Do you need to push up on the bulge to urinate? Yes No
5. Have you ever used a pessary (a device to hold things up)? Yes No

GROUP VI (other pelvic or sexual issues)

1. Are you sexually active at the present time? Yes No
 If “no,” is this because of your present problem? Yes No
 If “no,” is this because of decreased interest or sex drive? Yes No
2. Do you have pain with intercourse? Yes No
 Do you leak urine with intercourse? Yes No
3. Are you prone to yeast or other vaginal infections (more than one/year)? Yes No

4. Any history of sexually transmitted disease? Yes No

5. Do you have pain in the pelvic region? Yes No

If "yes," is it related to: sex urination bowel movement

Location of the pain: _____

6. Any history of sexual abuse? _____

GROUP VII (Check all that apply.) (other urogyn issues)

Blood in urine

Urinary hesitancy

Poor flow

Pain with urination

Straining to void

Unable to empty bladder

Recurrent urinary infections

Intermittent stream

Post-urination dribbling

Sometimes a "tummy tuck" or other cosmetic procedures can be done at the same time as surgery for urogynecological problems. This would be done by a plastic surgeon and is usually NOT covered by insurance BUT your hospitalization probably will be covered by insurance (if you need/want surgery with me).

Is this something you would consider? Yes No (Please let me know)