Last Name_____First Name_____Age_____

Date of Birth_____ Date of Appointment _____

Physician requesting consultation_____ Primary care doctor _____

Physician's specialty: ☐ Gyn/Ob ☐ Primary Care (FP/IM) ☐ Urology ☐ other: _____

Chief Complaint (Why do you want to see the doctor?)_____

_____

_____

SURGICAL HISTORY

__ Hysterectomy: Date_____ Reason: __Bleeding __Fibroids __Prolapse
Who did surgery? _____ Where?_____
Incision: __Abdomen __Vagina
Ovaries removed? N Y → if yes BOTH LEFT RIGHT

__ Bladder repair: Date_____ Reason: __Prolapse __Urinary leakage ___ Injury (describe:_____)
Who did surgery? _____Where?_____
Incision: __Abdomen __Vagina

__Other surgeries: _____ Reason: _____ Date:_____

_____ Reason: _____ Date:_____
_____ Reason: _____ Date:_____
_____ Reason: _____ Date:_____
_____ Reason: _____ Date:_____
_____ Reason: _____ Date:_____

PROLAPSE

Do you have a feeling of vaginal fullness, pressure, bulge or protrusion of any vaginal tissue? Y N

Bold box is for staff use

IF NO, SKIP TO NEXT SECTION. IF YES, COMPLETE BOX BELOW

1. **Are your symptoms worse at the end of the day or after standing for prolonged periods? Y N**
2. How long have you had this bulge or mass? Y N
3. Do you push the protrusion back to help with a bowel movement or to empty your bladder? Y N
4. Have you seen a doctor for this? Y N
5. Have you used a pessary for this problem? Y N
6. Have you had surgery for a bulge or mass in the vagina in the past? Y N

POP Notes: 1 2 3

URINARY INCONTINENCE

Do you have problems with urinary urgency/frequency or accidental loss of urine? *Y* *N*

IF NO, SKIP TO NEXT SECTION. IF YES, COMPLETE BOX BELOW

1. How many months or years have you had leakage of urine? ____mos ___yrs
2. Do you use pads to absorb lost urine? Y N
3. How many pads do you wear in a day? _____
4. About how many trips do you make to the bathroom during the day? _____
5. How many times do you wake at night to go to the bathroom? _____
6. Would you describe the amount of urine that you leak as being:
   - Frequent small volumes Y N
   - Unconscious/continuous loss (always damp or wet) Y N
   - Infrequent but single large volumes of loss Y N
7. Do you ever wet the bed while asleep? Y N
8. Are you bothered by a strong sense of urgency to void? Y N
9. Can you overcome the sensation of urgency to void? Y N
10. Do you sometimes not make it to the bathroom in time? Y N
11. Does the sound, sight, or feel of running water cause you to lose urine? Y N
12. Do you lose urine without any warning (without activity or feeling urgency to urinate)? Y N
13. If you are sexually active: Do you lose urine during intercourse? Y N
    Do you lose urine with deep penetration? Y N
    Do you lose urine during orgasm? Y N
14. Which best describes urine loss with activity ?
    1. I lose urine during coughing, sneezing, running, or heavy lifting? Y N
    2. I lose urine with changes in posture, standing, or walking? Y N
    3. I lose urine continuously such that I am constantly wet? Y N
    4. 'Key in the door' when you return home? Y N
15. Have you seen a physician for complaints of urine loss? Y N
16. Have you taken medication to prevent urine loss? Y N
17. If yes, name the medication:_____
18. Have you had surgery to prevent urine loss? Y N
19. The result of the surgery was: (Circle one)
    - € Helped temporarily (# of months_____)
    - € No difference
    - € Made it worse

Bold box is for staff use

UI Notes: 1 2 3

VOIDING DYSFUNCTION

Do you have problems with urinating or emptying your bladder completely? *Y* *N*

IF NO, SKIP TO NEXT SECTION. IF YES, COMPLETE BOX BELOW

1. Do you notice any dribbling of urine when you stand after passing urine? Y N
2. Do you usually have difficulty starting your urine stream? Y N
3. Do you have to assume abnormal positions to urinate? Y N
4. Do you strain to void your urine? Y N
5. Is your urine flow: (circle one) Strong Weak Dribbling Intermittent
6. Do you feel that your bladder is empty after passing urine? Y N

Void Dysfxn Notes: 1 2 3

DEFECATORY DYSFUNCTION

Do you have problems with your bowels? Y N

IF NO, SKIP TO NEXT SECTION. IF YES, COMPLETE BOX BELOW

Bold box is for staff use

Defec Dysfxn Notes:

1. **Do you have accidental loss of solid stool? Y N**
2. Do you have accidental loss of liquid stool? Y N
3. Do you have accidental loss of gas? Y N
4. How many months or years have you had accidental loss of stool or gas?_____
5. Did the problem begin after childbirth? Y N
6. How many episodes during a week?_____
7. Do you wear protective pads for this problem? Y N
8. How many pads each day?_____
9. Are you able to sense the need to have a bowel movement? Y N
10. Do you have a frequent desire to have a bowel movement? Y N
11. Do you feel that your bowels are never completely empty? Y N
12. Have you seen a doctor for this problem? Y N
13. Have you had surgery for this problem? Y N
14. Do you have constipation? Y N Do you have diarrhea? Y N
15. Problems with bloating? Y N
16. Do you excessively strain to pass stool more than 25% of the time? Y N
17. Do you have at least three bowel movements each week? Y N
18. Do you pass small, hard stool? Y N
19. How many months or years have you had constipation?_____
20. Have you seen a doctor for this problem? Y N
21. Have you ever used over the counter medication for this problem? Y N
    If yes, what medications have you used?_____
22. Have you had surgery for this problem? Y N
23. Do you ever place your fingers in your vagina or between the vagina and rectum to effect a bowel movement? Y N

Sex Dysfxn Notes 1 2 3

SEXUAL DYSFUNCTION

PLEASE COMPLETE BOX BELOW

1. Are you sexually active? Y N
2. Do you have pain with intercourse? Y N
   If yes is the pain with: penetration or deep thrusting
   If yes, how long has this been a problem?_____mos/yrs
3. Do you have difficulty with orgasm? Y N
4. Do you have difficulty with sexual desire? Y N
5. If not sexually active, is the reason due to:
   - € Decreased sex drive?
   - € Incontinence or leakage with intercourse?
   - € Vaginal problems (lubrication, pain) ?
   - € Partner problems (impotence, widowed) ?
   - € Pain
   - € Problems because of previous surgery
   - € Other:_____
6. Do you have other questions about sexual function you would like to discuss with the doctor? Y N

PAIN

Do you have pain? Y N

IF NO, SKIP TO NEXT SECTION. IF YES COMPLETE BOX BELOW

1. If yes, where is your pain: __Pelvic area __Vagina __Stomach
   __Back __Rectum
2. How long has pain been a problem?_____mos/yrs
3. What relieves your pain?_____
4. What makes your pain worse? _____
5. Past treatment(s):_____
6. Have you seen any other doctors? N Y
   if yes, what specialty(ies)_____
   if yes, what types of testing did they perform?_____
   _____

Bold box is for staff use

Pain notes 1 2 3

GYN HISTORY

Number of pregnancies: _____
Number of vaginal births: _____ did the doctors use either: __Forceps __Vacuum
Did you have a large tear? N Y → if yes, how big was your tear? __4th degree (it involved my rectum) __3rd degree
Number of c-sections: _____
Weight of largest baby: _____
Last menstrual period_____ OR Age at menopause: _____
Birth control method (if any): _____
If menopausal, hormone replacement: Y N
If yes, type: _____
Last PAP smear: _____
Last mammogram: _____
History of sexually transmitted diseases? Y N
If yes, type: _____& location of infection: _____

CURRENT MEDICATIONS (please include herbals and non-prescription also)

Medication Name (if you need more space, use back of this sheet)	**Dose (in mg)**	**How often?**

PAST MEDICAL HISTORY (check all that apply)

__Diabetes __ Kidney stones __Thyroid problems __Depression/Anxiety
__Osteoporosis __ High blood pressure __Arthritis __Asthma __Chronic cough
__Glaucoma __ Neurologic (nerve problems_____)
__Stomach problems __Cancer (which? _____when diagnosed? _____)
__High cholesterol __Heart problems (describe: _____)
__Other: _____

- **Of the above medical problems indicated, have any become worse or more severe in the last month? N Y**
  If yes, which one(s)? _____

DRUG ALLERGIES/Other Allergies	

SOCIAL HISTORY

Marital status __Single __Married __Divorced __Widowed
Alcohol use __Never __Rarely __Moderate __Daily
Tobacco use __Never __Quit __Current: # of cigarettes you smoke per day_____
Drug use __Never __Recreational __Daily Type: _____
Race or Ethnicity: __White __Black __Native American __Hispanic __Middle Eastern __Southeast Asian __other: _____
Occupation: _____Does your work involve lifting of weights over 10 pounds? Y N

Do you work: __FULL TIME __PART TIME
Exercise: N Y → if yes how often do you exercise? _____

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

___ Bladder problems (bladder drop, urine leakage)_____
___ Cancer _____
___ Bleeding Disorder _____
___ Heart Disease _____
___ Connective Tissue (Ehlers Danlos, Marfan's, Osteogenesis imperfecta) _____
___ Neurologic Disorders _____

REVIEW OF SYSTEMS (circle all that apply)

Recent weight change	Fever	Fatigue	☐ All ROS were reviewed
Hearing loss	Chronic sinus problems	Sore throat	& are negative
Voice change	Chest pain	Palpitations	
Swelling	Chronic cough	Shortness of breath	
Nausea	Vomiting	Frequent diarrhea	
Bloody bowel movements	Painful bowel movements	Painful periods	
Vaginal discharge	Blood in urine	Joint pain/stiffness	
Muscle pain/stiffness	Back pain	Rash/itching	
Breast pain/lump	Varicose veins	Headache/dizziness	
Convulsions/seizures	Paralysis/numbness	Memory loss/confusion	
Depression	Heat/cold intolerance	Excessive thirst/urination	
Gland/hormone problem	Bleeding/bruising tendency	Anemia/past transfusion	

Your Daily Bladder Diary

Your name: _____

This diary will help you and your health care team understand your bladder function.
It is a 24 hour record of your intake and output as well as leakage episodes. Date: _____
The "sample" line (below) will show you how to use the diary.

					ACCIDENTS					
Time	**Drinks**		**Urine**		**Accidental Leaks**			**Did you feel a strong urge to go?**		**What were you doing at the time?**
					How much? (check one)					
	What kind?	How much?	How many times did you "pee" during the hour?	How much? Use measuring cup (ml's or oz's)	♦♦ sm	med	lg	Circle one		Sneezing, exercising, havng sex, lifting, etc.
Sample	*Coffee*	*2 cups*	*2*	2 oz or 2 ml	Ö			Yes	No	*Running*
6-7 am								Yes	No	
7-8 am								Yes	No	
8-9 am								Yes	No	
9-10 am								Yes	No	
10-11 am								Yes	No	
11-12 noon								Yes	No	
12-1 pm								Yes	No	
1-2 pm								Yes	No	
2-3 pm								Yes	No	
3-4 pm								Yes	No	
4-5 pm								Yes	No	
5-6 pm								Yes	No	
6-7 pm								Yes	No	
7-8 pm								Yes	No	
8-9 pm								Yes	No	
9-10 pm								Yes	No	
10-11 pm								Yes	No	
11-12 mid								Yes	No	
12-1 am								Yes	No	
1-2 am								Yes	No	
2-3 am								Yes	No	
3-4 am								Yes	No	
4-5 am								Yes	No	
5-6 am								Yes	No	