

## Urogynecology and Pelvic Reconstructive Surgery Obstetrics, Gynecology and Women's Health

### Medical History Questionnaire

Patient's Name: \_\_\_\_\_ Date Form Filled: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Physician Information**

Name of Referring Physician: \_\_\_\_\_

Name of Primary Physician: \_\_\_\_\_

**Present Condition**

In your own words, describe why you have been asked to come here: \_\_\_\_\_

**Problems**

- Yes  No Do you leak urine with coughing, sneezing, laughing, etc.?
- Yes  No Do you leak urine trying to get to the bathroom in time?
- Yes  No Do you urinate too frequently?
- Yes  No Do you wake up at night to urinate?
- Yes  No Is it hard to empty your bladder?
- Yes  No Is constipation a problem?
- Yes  No Do you lose bowel movement or gas by accident?
- Yes  No Is there pressure in your bottom or bulge of your female organs?
- Yes  No Do you have a lot of bladder or urinary infections?

**Medical Problems** Please check "Yes" or "No" for each problem.

- |   |  |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal pap                       | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis                          | <input type="checkbox"/> Yes <input type="checkbox"/> No Cataracts                 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer                             | <input type="checkbox"/> Yes <input type="checkbox"/> No Congenital heart disease  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Crohn's disease/Ulcerative colitis | <input type="checkbox"/> Yes <input type="checkbox"/> No DVT (blood clots)         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Depression                         | <input type="checkbox"/> Yes <input type="checkbox"/> No Fibromyalgia              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/seizures                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Gonorrhea                 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma                           | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart problems            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart murmur                       | <input type="checkbox"/> Yes <input type="checkbox"/> No Herpes                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heartburn/GERD                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Hypertension              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No HPV                                | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney disease            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Intestinal cystitis                | <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis/penia        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Migraines                          | <input type="checkbox"/> Yes <input type="checkbox"/> No Sickle cell disease       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Sickle cell trait                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid disease           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Syphilis                           | <input type="checkbox"/> Yes <input type="checkbox"/> No Type 1 diabetes           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis                       | <input type="checkbox"/> Yes <input type="checkbox"/> No Anesthetic complications  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia                             | <input type="checkbox"/> Yes <input type="checkbox"/> No Bladder/kidney infections |

**Medical Problems (Continued)** Please check “Yes” or “No” for each problem.

- |   |   |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chlamydia                | <input type="checkbox"/> Yes <input type="checkbox"/> No Irritable bowel syndrome |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Congestive heart failure | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney stones            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema/COPD           | <input type="checkbox"/> Yes <input type="checkbox"/> No Pulmonary embolus        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Gestational diabetes     | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart attack             | <input type="checkbox"/> Yes <input type="checkbox"/> No Trichomonas              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis: viral         | <input type="checkbox"/> Yes <input type="checkbox"/> No Type 2 diabetes          |
| <input type="checkbox"/> Yes <input type="checkbox"/> No HIV/AIDS                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Other (please list)      |

**Surgical History** Please check “Yes” or “No” for each problem.

- |  |   |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Appendectomy              | <input type="checkbox"/> Yes <input type="checkbox"/> No Single ovary removed   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cervical cerclage         | <input type="checkbox"/> Yes <input type="checkbox"/> No Abdominal hysterectomy |
| <input type="checkbox"/> Yes <input type="checkbox"/> No C-Section                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Vulvar biopsy          |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hernia repair             | <input type="checkbox"/> Yes <input type="checkbox"/> No Cervical biopsy        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mastectomy                | <input type="checkbox"/> Yes <input type="checkbox"/> No Cervical cone biopsy   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tonsillectomy             | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart bypass surgery   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tubal ligation            | <input type="checkbox"/> Yes <input type="checkbox"/> No LEEP                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Ovaries and tubes removed | <input type="checkbox"/> Yes <input type="checkbox"/> No Ovarian cyst removed   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Gallbladder removed       | <input type="checkbox"/> Yes <input type="checkbox"/> No Vaginal hysterectomy   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No D & C                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Other (list)           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hysteroscopy              |   |

**Family Medical History**

What have your family members suffered from medically?

Medical Problem	Which relative(s) had this?
Diabetes	
Breast cancer	
Ovarian cancer	
Colon cancer	
Uterine cancer	
Osteoporosis	
Heart disease	
Hypertension	
Hyper cholesterol	
Clot in lung	
Depression	
Stroke	
Heart failure	
Thyroid disease	
Other- list	

**Social History** Tell us about yourself and your habits.Tobacco Use:  I currently smoke \_\_\_\_\_ pack(s)/day for \_\_\_\_\_ years I have never smoked I used to smoke, but quit in \_\_\_\_\_ I have only been exposed to passive smoke (other smoke, but not me) I use chewing tobaccoAlcohol Use:  I do not drink alcohol I currently use alcohol, and drink about \_\_\_\_\_ drinks a weekStreet Drug Use:  Yes, I use street drugs List kinds: \_\_\_\_\_ No, I don't use street drugs**Gynecological History**Are you sexually active?  Yes  NoDo you use birth control?  Yes  No If yes, I use: \_\_\_\_\_

Last menstrual period: \_\_\_\_\_

Total pregnancies: \_\_\_\_\_

Number of deliveries: \_\_\_\_\_

Number of living children: \_\_\_\_\_

Weight of largest baby born vaginally: \_\_\_\_\_

Number of deliveries using forceps: \_\_\_\_\_

Number of deliveries using vacuum: \_\_\_\_\_

Torn into rectum during delivery of baby(s)? Yes No

Occupation: \_\_\_\_\_  Unemployed  RetiredLast pap smear: Date: \_\_\_\_\_  Normal  AbnormalLast Mammogram: Date: \_\_\_\_\_  Normal  Abnormal

**Review of Systems** Please check those that have bothered you in the last few months.

Constitutional

- Fever
- Chills
- Sweats
- Fatigue
- Malaise
- Anorexia
- Weight loss

Eyes

- Contacts/Glasses
- Cataracts
- Glaucoma
- Visual disturbance
- Irritation
- Redness
- Yellow in Eyes

Ears, nose, mouth, throat, and face

- Hearing loss
- Ringing in the ears
- Ear drainage
- Earache
- Nasal congestion
- Bloody nose
- Snoring
- Sore mouth
- Sore throat
- Hoarseness

Respiratory

- Cough
- Sputum
- Coughing up blood
- Sharp pain with breathing
- Pneumonia
- Asthma
- Wheezing
- Shortness of breath with exertion
- Emphysema

Cardiovascular

- Chest pain
- Chest discomfort
- Shortness of breath
- Palpitations
- Irregular heart beat
- Fainting

Gastrointestinal

- Difficulty swallowing
- Painful swallowing
- Heartburn
- Nausea
- Vomiting
- Change in bowel habits
- Bloody or black bowel movement

Genitourinary

- Frequent urination
- Painful urination
- Waking up at night to urinate
- Leaking urine
- Difficulty urinating
- Decreased stream
- Blood in urine

Integument/breast

- Rash
- Skin lesion(s)
- Dryness
- Skin color change
- Changed mole
- Breast lump
- Nipple discharge

Hematologic/lymphatic

- Easy bruising
- Easy bleeding
- Swollen glands
- Broken blood vessels on skin

Musculoskeletal

- Muscle pain
- Joint pain
- Stiff joints
- Neck pain
- Back pain
- Muscle weakness
- Bone pain

Neurological

- Headaches
- Dizziness
- Seizures
- Memory problems
- Speech problems
- Tingling/numbness
- Coordination problems
- Difficulty walking
- Tremor
- Weakness

Behavioral/Psych

- Anxiety
- Depression
- ADHD
- Bipolar disorder
- Alcoholism

Endocrine

- Diabetes
- Fertility problems
- Temperature intolerance

Allergic/immunologic

- Rashes
- Hay fever
- Anaphylaxis

### Voiding Diary/Urolog Instructions

The chart on the next page is a record of your voiding (urinating) and incontinence (leakage) of urine. Please complete this according to the following instructions prior to your visit to our office. Choose a 24-hour period to keep this record when you can conveniently measure every voiding, and begin your record with the first voiding upon rising.

**EXAMPLE:**

1. Time	2. Voided Volume	3. Leak Volume	4. Urge Present	5. Activity	6. Amount/Type Intake
6:45 <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	550 <input checked="" type="checkbox"/> CC <input type="checkbox"/> OZ	1 2 3	Yes No	Awakening	
7:00 <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> CC <input type="checkbox"/> OZ	1 2 3	Yes No	Turned on water	2 cups coffee 6 oz. OJ

- 1. Time:** Record time of all voids, leakage, intake of liquids and activity.
- 2. Voided:** Measure all intake and urine output in cc's or oz. (1 cup = 240 cc's)
- 3. Leak Volume:** Estimate the amount of leakage according to the following scale:
  - 1 = damp, few drops only
  - 2 = wet underwear or pad
  - 3 = soaked or emptied bladder
- 4. Urge Present:** If the urge to urinate is accompanied (or preceded the urine leakage) check "Yes." If you felt no urge when leaking occurred check "No."
- 5. Activity:** Describe activity you were performing at the time of leakage. If you were not actively doing anything, record whether you were sitting, standing, or lying down.
- 6. Activity/Type Intake:** Record the amount and type of liquid intake using either cc's or oz. (1 cup = 240 cc's)

### Voiding Diary/Urlog

1. Time	2. Voided Volume	3. Leaked Volume	4. Urge Present	5. Activity	6. Amount/Type Intake
<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> CC <input type="checkbox"/> OZ	1 2 3	Yes No		
<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> CC <input type="checkbox"/> OZ	1 2 3	Yes No		
<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> CC <input type="checkbox"/> OZ	1 2 3	Yes No		
<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> CC <input type="checkbox"/> OZ	1 2 3	Yes No		
<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> CC <input type="checkbox"/> OZ	1 2 3	Yes No		
<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> CC <input type="checkbox"/> OZ	1 2 3	Yes No		
<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> CC <input type="checkbox"/> OZ	1 2 3	Yes No		



