

FOR NEW UROGYN PATIENTS ONLY

URO GYN Questionnaire / UROGYNECOLOGY CLINIC/ FBCH

Please complete the following questionnaire. Please leave items blank that you do not understand.

Name: _____ Date: _____ Age: _____

Telephone: _____ E-Mail: _____

Why are you here to see Urogyn? _____

Prolapse:

Do you feel a vaginal bulge? yes..... no
Pressure?..... yes..... no
Do you have to place your fingers in the vagina or in the rectum to have a bowel movement? yes..... no
Does prolapse interferes with intercourse?.... yes..... no
Have you ever tried a pessary? yes..... no
Impact to quality of life? (circle) **Minimal, Moderate, Severe**

Stress Incontinence:

Do you leak urine with cough, sneeze, exercise yes. no
How often do you leak with cough, sneeze, exercise
(circle) **Occasional, Weekly, Daily**
How much do you usually leak? drops more soak
Do you wear a pad?.. yes no.. If so; light, large, diapers
Impact to quality of life? (circle) **Minimal, Moderate, Severe**

Urge Incontinence:

Do you often get sudden urges to urinate? yes..... no
How often do have urges? (circle) **Occasional, Weekly, Daily**
If so, do you leak with these urges? yes..... no
How much do you usually leak?..... drops more soak
Impact to quality of life? (circle) **Minimal, Moderate, Severe**

How many times do you go to the bathroom per day? _____
How many times do you go to the bathroom per night? _____

Urinating:

Difficulty starting urination or strain to void?.... yes..... no
Weak or intermittent stream?..... yes..... no
Incomplete emptying or dribbling?..... yes..... no
Pain or burning with urination?..... yes..... no

Intake:

How many 8 oz drinks of caffeine per day?..... _____
How many 8oz drinks of liquid (total intake) per day? _____

GI:

Constipation?..... yes..... no
Frequency stools (circle) **Daily, Less often, More often**
Straining for stools..... yes..... no
Stool consistency (circle) **Normal, Loose, Hard**
Ever leak stool (Accidental Bowel Leakage)?.. yes.... no
If so, how often? **occasional, weekly, daily**
If so, do you leak? **gas, liquid, solid**
Soiling without sensation?..... yes..... no
History of irritable bowel or Crohn's?..... yes..... no

Sexual/Pain:

Are you currently having sex?. (if no, why):... yes..... no
Pain with sex? **none, occasional, most times, every time**
Pain with sex? **none, mild, moderate, severe**
Sexual Partner:..... Male... Female... Both

Do you have problems with orgasm?..... yes..... no
Decreased sexual sensation?..... yes..... no
If so where? (circle) **Clitoral, Vaginal, Labial**
Urinary symptoms interfere with sex?..... yes..... no
Impact to quality of life? (circle) **Minimal, Moderate, Severe**

Prior therapy:

Ever done pelvic floor physical therapy? yes.. no
Trial of medication? yes.. no

Medical History: Do you have?

Cholesterol?..... yes.. no Diabetes yes.. no
Blood pressure? yes.. no Recurrent UTIs? yes.. no
Sleep Apnea? yes.. no
List other medical problems: _____

Surgical History: (Please list surgeries and year performed)

Hysterectomy _____
 Bladder Surgery _____
 Other: _____

OB/Gyn History:

How many times have you been pregnant? _____
How many deliveries? _____
Vaginally___ Cesarean Section___
What do you use to prevent pregnancy? _____
Are your periods regular?.. yes... no _____
When was the first day of your last period? ___/___/___
Last Pap smear? (year) _____ Any abnormal?.. yes... no
Last mammogram? _____ Last colonoscopy? _____

Medications/Vitamins/Supplements:

Drug Allergies: None or List (include reaction)

Family History: (list relationship and age at diagnosis)

Breast cancer _____ Ovarian cancer _____
 Colon cancer _____ Other: _____

Social History:

Single Married Divorced
 Separated Widowed Domestic Partner
Do you smoke cigarettes?..... yes..... no
Drink more than 1 alcoholic beverage a day? yes..... no
Occupation? _____