UROGYNECOLOGY PATIENT QUESTIONNAIRE

Date of Appointment:____/____/____
Patient Name _____ Date of Birth:_____
which physician are you seeing today? Dr. Carley Dr. Boreham Dr. Roshanravan Dr. Kinman

Referring healthcare provider name/address:
_____
Do you have a gynecologist who you have seen in the last 5 years? _____
Gynecologist name and number: _____
Primary care physician name and number: _____
Pharmacy phone number: _____
If you were referred by a healthcare provider, may we send correspondence regarding your visit and care?
Yes No
What bothers you most about your bladder or pelvic organs? (Please describe in your own words)
_____
_____
How long have you had this? _____
The problem is getting *(Please circle one)*: **worse better no change**
Please list any other concerns regarding your bladder or pelvic organs you wish to discuss during your visit
_____
_____

1. Do you lose urine with any of the following activities: (Circle any that apply)

a. Coughing	b. Walking	c. Lifting
d. Exercise	e. Sneezing	f. Laughing
g. Clearing your throat	h. Running	i. Standing up
j. Orgasm	k. Pressure during intercourse	l. Washing your hands
m. Seeing water	n. Putting the key in the door	o. Showering
p. Cold weather	q. Other_____	r. Other_____

2. From the list above, during what 3 situations does your urine loss most bother you?
_____ _____ _____
3. How much does your urine loss bother you?
(Please circle one) **not-at-all slightly moderately greatly**
4. Do you ever lose urine while lying down? ……..**Yes No**
5. Do you ever have a sudden urge to void and lose urine before you reach the toilet? ……**Yes No**
If so, how much does this bother you?
(Please circle one) **not-at-all slightly moderately greatly**
6. Circle the following word to best describe your urgency feeling when your bladder is full.
(Please circle one) **none mild moderate severe**
7. Do you ever leak urine suddenly without an urge while sitting quietly? ……...**Yes No**
8. Do you experience complete bladder emptying for no apparent reason? ……..….**Yes No**
9. Are you aware of the urine loss? ……**Yes No**
10. Did you have bedwetting problems beyond age 5? …… **Yes No**
11. Do you wake up wet at night? ……**Yes No**
12. Have you wet the bed in the past year? …….. **Yes No**
13. Did your urine problem start after childbirth? ……..……... **Yes No**

14. Did your urine problem start after an operation? …… **Yes** **No**
15. Did your urine problem start after X-ray treatment? …….. **Yes** **No**
16. Do you dribble urine when you stand up or cough after voiding……..……. **Yes** **No**
17. Do fits of laughter cause complete emptying of your bladder?…….…….. **Yes** **No**
18. Do you lose urine in drops? …… **Yes** **No**
19. Do you lose urine in large amounts? …….. **Yes** **No**
20. Do you lose urine in spurts? ……... **Yes** **No**
21. Do you lose urine as a constant stream? …… **Yes** **No**
22. How many times do you leak urine per day? _____
23. If not daily, how many times do you leak urine per week? _____
24. Do you use a protective pad? …….. **Yes** **No**
    If so, how many per day _____ per night _____
25. Have you modified any of the following activities because of urine loss: *(Circle any that apply)*
    Travel
    Social activities
    Physical recreation (exercise, walking, sports)
    Other _____
26. Do you feel it is bad enough to consider surgery? …….. **Yes** **No**
27. Do you have a strong desire to void often? …… **Yes** **No**
28. Do you void often for fear of leaking? ……... **Yes** **No**
29. Do you void often because of bladder pain or fear of pain? ……... **Yes** **No**
30. Do you have pain during voiding? ……..…… **Yes** **No**
    If so when does is occur? *(Circle all that apply)*
    Only at the end of voiding **Only when an infection is found** **After voiding**
31. Do you have pain as your bladder fills and decreased pain after voiding? …… **Yes** **No**
32. How many times do you void (urinate) during the day? _____
33. How many times do you awaken from sleep to void? _____
34. Does it take you a long time to start voiding? …… **Yes** **No**
35. Do you assume different positions to help empty your bladder? ……... **Yes** **No**
36. Do you strain to empty your bladder? …… **Yes** **No**
37. Do you put pressure on the lower abdomen to start urination? …….. **Yes** **No**
38. Is your stream weak or prolonged? …… **Yes** **No**
39. Do you have a sensation of incomplete emptying after voiding? ……... **Yes** **No**
40. Does the stream start and stop during urination? …… **Yes** **No**
41. Do you feel vaginal or pelvic pressure? …… **Yes** **No**
42. Do you see or feel something protruding from the vagina? ……... **Yes** **No**
43. Have you used a pessary (device to hold up pelvic organs) in the past? …… **Yes** **No**
44. Do you press around the anus or in the vagina during bowel movements? …… **Yes** **No**
45. Do you have fecal staining on your underwear? …… **Yes** **No**
46. Do you lose control of intestinal gas (flatus)? …… **Yes** **No**
47. Do you lose control of liquid stools? …….. **Yes** **No**
48. Do you lose control of formed stools? …… **Yes** **No**
49. Do you have problems with constipation? …….. **Yes** **No**
50. Do you have any blood in your stool? …… **Yes** **No**
51. Have you been treated for 3 or more bladder or kidney infections in your life? …… **Yes** **No**
52. Have you been treated for a bladder or kidney infection within the past year? …… **Yes** **No**
    If yes, how many infections have you had within the past year? _____
    When was the last one? _____
53. Do they occur one or 2 days after intercourse? ……... **Yes** **No**

54. Have the infections been diagnosed by urine cultures? …….. **Yes** **No**
55. Is your urine ever bloody? …… **Yes** **No**
    If so, is it painful when you notice the bleeding? _____
56. Have you ever passed gravel, sand, or stones in your urine? ……..**Yes** **No**
57. Have you ever been treated for kidney or bladder tumors? …… **Yes** **No**
58. Are you sexually active? …… **Yes** **No**
    If so, how often do you have intercourse? _____
59. Do you have any discomfort with intercourse? …….. **Yes** **No**
60. Do you have any vaginal dryness with intercourse? ……... **Yes** **No**
61. Are you or your partner having sexual difficulties or concerns?.....…… **Yes** **No**
62. Would you like treatment for any sexual concerns?..... **Yes** **No**
63. Do you smoke? **Never** **No** **Yes** If yes how many packs per day? _____
64. How many 8 oz. glasses of water do you drink a day? _____
65. How many 8 oz. glasses of other fluids do you drink a day? _____
    What types of fluids other than water do you normally drink in a day?
    Coffee___oz., Tea____oz., Soda_____oz., Alcoholic Beverages_____oz, Fruit juices_____oz
66. Have you had any prior treatment for urinary leakage? …… **Yes** **No**
67. Have you had an operation for urinary leakage? …… **Yes** **No**
68. Have you ever taken medication for urinary leakage? …… **Yes** **No**
69. Please list any other treatments you have had for urinary leakage_____
70. Do you have mitral valve prolapse? …… **Yes** **No**
71. Do you have an artificial heart valve? …… **Yes** **No**
72. Do you have a joint (hip, knee, etc.) replacement? …… **Yes** **No**
73. Do you ever use antibiotics before any procedure for any reason? …… **Yes** **No**
    If yes, please list the reason(s) _____
74. Do you have any of the following medical conditions: *(circle any that apply)*

a. Diabetes Mellitus	b. Thyroid disease	c. Pernicious anemia
d. Paralysis	e. Stroke	f. Multiple Sclerosis
g. Parkinson's Disease	h. Back or Brain surgery	i. Fibromyalgia
j. Blood clots in legs/lungs	k. Chronic cough	l. Smoking
m. Pacemaker	n. Heart failure	o. Weight problems
p. Glaucoma	q. Other_____	r. Other_____

75. List any medications that you are currently taking (please include any vitamins or non-prescription medications).

    _____

    _____

76. Please list all allergies and the reaction you have to them:

Allergies	***Reaction Experienced***

77. Please list any additional medical conditions for which you have received medical treatment in the past.

    _____

    _____

    _____

78. Have you had any of the following operations/procedures? *(If yes, please include the year and reason for each procedure)*

Surgery/Procedure	**Year**	**Reason for the surgery/procedure**
Removal of the uterus		
Removal of the ovaries		
Bladder surgery		
Brain/Back surgery		
Cystoscopy		
Urodynamic study		
Urethral dilation		
Other		

79. If you have had your uterus removed was it performed through the abdomen or vagina? _____
80. If you have had bladder surgery was it performed through the abdomen or vagina? _____
81. How many pregnancies have you had? _____
82. How many vaginal deliveries have you had? _____
83. How many Cesarean deliveries have you had? _____
84. Were forceps used for any of your deliveries? _____
85. Did you have an episiotomy for any of your deliveries? _____
86. What was the birth weight of your largest baby? _____
87. When was your last childbirth? _____
88. What is the date of your last menstrual period? _____
89. What type of contraception are you using? _____
90. What is the date of your last Pap smear? _____
91. What is the date of your last mammogram? _____
92. Are you menopausal?…….. **Yes** **No**
    If so, have you ever taken hormones?……**Yes** **No**
    Are you currently taking hormones?……..**Yes** **No**
93. If you had previously taken hormones, but are not now, when did you stop taking them? _____
94. If you had previously taken hormones, but are not now, why did you stop taking them? _____
95. Do any family members have a history of urine loss? ……**Yes** **No**
    If so, what relationship? _____
96. Do any family members have a problem with vaginal prolapse or protrusion? ……**Yes** **No**
    If so, what relationship? _____
97. Do you have a **FAMILY HISTORY** of the following? If so, whom?

	Father's Family	**Mother's Family**	**Siblings, Children, Nieces, Nephews**
Breast Cancer:			
Colon Cancer:			
Ovarian Cancer:			

Have any men in your family developed heart disease before age 55? **Y / N**

Have any women in your family developed heart disease before age 65? **Y / N**

ADDITIONAL REVIEW OF SYSTEMS: If you are currently having any problems in the following areas, ***please circle and explain*.**

CONSTITUTIONAL SYMPTOMS	Chills/fever, fatigue, weakness/poor energy level, unexplained weight change.
EYES	Sudden loss or change in vision, blurred or double vision, burning or itching; excessive tearing, redness, discharge, glaucoma, cataracts, other
EAR/NOSE/ MOUTH/THROAT	Sensitivity to noise, ear pain, ringing in ears, vertigo, sinus infection, nose bleeds, frequent sneezing/nasal drainage, difficult breathing, dry mouth, sore throat, bleeding gums, difficulty swallowing or inability to taste, other
CARDIOVASCULAR	Chest pain, palpitations, heart murmurs, irregular pulse, color change in fingers/toes, swelling in ankles, leg pain when walking, high/low blood pressure, high cholesterol, congestive heart failure, pacemaker/defibrillator, other
RESPIRATORY	Cough, phlegm, chest pain on deep inhalation, wheezing, shortness of breath, difficulty breathing, asthma, other
GASTROINTESTINAL	Abdominal pain, nausea/vomiting, indigestion/heartburn, constipation/diarrhea, other
MUSCULOSKELETAL	Bone/muscle/joint pain, muscle cramps, stiffness, noise with joint movement, other
INTEGUMENTARY (SKIN)	Itching, rash, skin tags, changes of: scars, moles, sores, lesion, nail color or texture, other
BREASTS	Breast pain, tenderness or swelling, lumps, cysts, pain prior to menstruation, history of nipple discharge or changes, other
NEUROLOGICAL	Numbness, tingling, dizziness, fainting or unconsciousness, seizures or convulsions, memory loss, attention difficulties, inability to concentrate, speech or language dysfunction, sensory/motor disturbances including the gait, balance, and coordination, tremor or paralysis, other
PSYCHIATRIC	Depression, excessive worrying, stress, suicidal thoughts, persistent sadness, anxiety, loss of pleasure from usual activities, loss of energy, restlessness, irritability, excessive mood swings, other
ENDOCRINE	Sudden changes in height and/or weight, increased appetite or thirst, intolerance to heat or cold, changes in hair distribution or skin pigment
HEMATOLOGIC/ LYMPHATIC	Easy bruising, fevers which come and go, swollen glands, night sweats, unusual bleeding, other
ALLERGIC/ IMMUNOLOGIC	Allergies to medications or foods, latex, hay fever. Hives and/or itching, frequent sneezing, chronic or clear postnasal drip, conjunctivitis, history of chronic infection, other

Thank you for taking the time to complete this questionnaire.