Blue Ridge Urogynecology

As a new patient we ask that you review and complete this questionnaire prior to arriving at the clinic so that we can better understand your health history. Completing this questionnaire will help us be better prepared to address your particular health needs. We look forward to meeting you.

Date: ____

Name: ____ Age: ______________

Address: ____ Birthdate: ______________

____

____

Telephone numbers

Home: _________________ Mobile: _________________ Work: _________________

Which telephone numbers may be call you at? Home Mobile Work

Which telephone numbers may we leave messages at? Home Mobile Work

Which **pharmacy** would you like us to call in or fax prescriptions to?

____

Provider who **referred** you:	Your **Primary Care Provider**:
Name________________________________	Name________________________________
Address______________________________	Address______________________________
City______________State____ZipCode______	City_______________State____ZipCode________
Phone number:_________________________	Phone number:_________________________
Fax number:___________________________	Fax number:___________________________

Your **Cardiologist**:	Please list the names and addresses of any other doctor you would like us to communicate with:
Name________________________________	Name________________________________
Address______________________________	Address______________________________
City______________State____ZipCode______	City_______________State____ZipCode________
Phone number:_________________________	Phone number:_________________________
Fax number:___________________________	Fax number:___________________________

MD Signature:___________________________________ Date: ____________________

What is the **reason for you visit:**

____

____

____

Please answer the following questions about **URINATION:**

How frequently do you urinate during the day?	Every ____ hours	
How many times do you get up at night to urinate?	times	
Do you ever wet the bed?	☐ Yes	☐ No
Do you completely empty your bladder when you void?	☐ Yes	☐ No
Do you have trouble starting your stream of urine?	☐ Yes	☐ No
Do you notice any change in your stream of urine?	☐ Yes	☐ No
Do you ever dribble urine?	☐ Yes	☐ No
Do you need to wear pads for protection from urine leakage?	☐ Yes	☐ No
Have you had 3 or more urinary tract infections in the past year?	☐ Yes	☐ No

On an average day how much do you drink? List below.

Type of Fluid	Amount	Type of Fluid	Amount
Example: decaf coffee	*2 8oz cups*		

Please circle your **best response** to the following questions**:**

Does coughing gently cause you to lose urine?	Never	Rarely	Sometimes	Often
Does coughing hard cause you to lose urine?	Never	Rarely	Sometimes	Often
Does sneezing cause you to lose urine?	Never	Rarely	Sometimes	Often
Does lifting things cause you to lose urine?	Never	Rarely	Sometimes	Often
Does bending cause you to lose urine?	Never	Rarely	Sometimes	Often
Does laughing cause you to lose urine?	Never	Rarely	Sometimes	Often
Does walking briskly or jogging cause you to lose urine?	Never	Rarely	Sometimes	Often
Does straining, if you are constipated, cause you to lose urine?	Never	Rarely	Sometimes	Often
Does getting up from a sitting position cause you to lose urine?	Never	Rarely	Sometimes	Often

Some women receive very little warning but suddenly find that they are losing or about to lose urine beyond their control. How often does this happen to you?	Never	Rarely	Sometimes	Often
If you can't find a toilet or find that the toilet is occupied, and you have an urge to urinate, how often do you end up losing urine or wetting yourself?	Never	Rarely	Sometimes	Often
Do you lose urine when you suddenly have the feeling that your bladder is very full?	Never	Rarely	Sometimes	Often
Does washing your hands cause you to lose urine?	Never	Rarely	Sometimes	Often
Does cold weather cause you to lose urine?	Never	Rarely	Sometimes	Often
Does drinking cold beverages cause you to lose urine?	Never	Rarely	Sometimes	Often

Please answer the following questions about your **BOWELS:**

Do you feel you need to strain hard to have a bowel movement?	☐ Yes	☐ No
Do you feel you completely empty your bowels at the end of a bowel movement?	☐ Yes	☐ No
Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	☐ Yes	☐ No
Do you ever accidentally lose stool?	☐ Yes	☐ No
Do you ever accidentally loose gas from the rectum?	☐ Yes	☐ No
Do you need to wear pads for protection from leakage of **stool**?	☐ Yes	☐ No

Circle the one number that best describes how your urinary symptoms are now.	Normal 1	Mild 2	Moderate 3	Severe 4
Do you usually have a sensation of bulging or protrusion from the vaginal area?	☐ Yes	☐ No		
Do you usually have a bulge or something falling out That you can see for feel in the vaginal area?	☐ Yes	☐ No		

Please answer the following questions about your **OBSTETRICAL AND GYNECOLOGIC HISTORY**

How many times have you been pregnant?	________ Times	
How many children did you deliver?	_________________	
Of these how many were delivered:	_________Vaginally	_________By C-Section
How big was your biggest baby?	______ lbs _____ oz	
What was your age at each delivery?	__________________	

MD Signature:__________________________________ Date: __________________

Did you have any problems with any of your deliveries?	☐ Yes	☐ No
Have you experienced menopause?	☐ Yes – please answer the questions below:	☐ No – please answer the questions below:
	How old were you when you went through menopause? _______ years old	Date of your Last Menstrual Period _____________
	Do you take hormone replacement? ☐ Yes ☐ No	Periods come every _______ days and last _______ days
	If yes, list the type _________	Do you have problems with your periods? ☐ Yes ☐ No
	How long have you taken hormone replacement? __________ years	Do you use Birth Control? ☐ Yes ☐ No If yes list method ____________

Are you sexually active?	☐ Yes	☐ No	
Is sexual intercourse painful for you?	☐ Yes	☐ No	
Do you leak urine during intercourse?	☐ Yes	☐ No	
In your life, have you ever been sexually or physically abused?	☐ Yes	☐ No	
Have you had any sexually transmitted infections?	☐ Yes	☐ No	
Have you ever had an abnormal Pap smear?	☐ Yes	☐ No	Date of last Pap smear _____________
Have you had an abnormal mammogram?	☐ Yes	☐ No	Date of last mammogram _____________
Have you ever had an abnormal colon screen?	☐ Yes	☐ No	Date of last colon screening (colonoscopy or sigmoidoscopy) _______________
Have you ever had an abnormal bone density scan?	☐ Yes	☐ No	Date of last bone density scan _______________
Have you ever had pelvic radiation for any reason?	☐ Yes	☐ No	

MD Signature:________________________________ Date: __________________

Name: ________________________________ Visit Date:_____________

Please answer these questions about your **MEDICAL HISTORY**

Check all appropriate boxes.

Heart Problems	**Lung Problems**	**Bowel Problems**	**Neurologic Problems**
☐ Heart Disease	☐ Asthma	☐ Bowel Disease	☐ Parkinson's Disease
☐ High Blood Pressure	☐ Pneumonia	☐ Ulcers	☐ Multiple Sclerosis
☐ Heart Murmur	☐ Tuberculosis	☐ Diverticulitis	☐ Stroke
☐ Heart Attack	☐ Emphysema	☐ Liver disease	☐ Back injury
Endocrine Problems	**Bleeding problems**	**Other**	
☐ Diabetes	☐ Bleeding problem	☐ Kidney Disease	
☐ Thyroid Disease	☐ Blood clot problem	☐ Arthritis	
☐ Osteoporosis	☐ Aspirin use	☐ Glaucoma	
☐ Chronic Steroid Use		☐ Cancer	

Please tell us more about anything that was checked above, or about any other problems:

____

____

PAST SURGICAL HISTORY: Please list the surgeries you have had:

Operation	Date	Surgeon	Hospital

MEDICATIONS: Please list all your current medications (include herbal and non-prescription medications):

Medicine	Dose	Medicine	Dose

MD Signature:____________________________ Date: ________________

ALLERGIES

List the things you are **allergic** to. Include medications, food, and environmental allergies.

____ ☐ I do not have any allergies

Have you ever used any medicines to help control your bladder or bowels?

____ ☐ I have not used medications

FAMILY HISTORY

Please note if anyone in your family has a history of any of these diseases:

			Family Member(s)
Breast Cancer	☐ Yes	☐ No	________________________
Ovarian Cancer	☐ Yes	☐ No	________________________
Other Cancer	☐ Yes	☐ No	________________________
Heart Disease	☐ Yes	☐ No	________________________
Diabetes	☐ Yes	☐ No	________________________
High blood pressure	☐ Yes	☐ No	________________________
Osteoporosis	☐ Yes	☐ No	________________________
Urinary incontinence	☐ Yes	☐ No	________________________

DAILY ACTIVITIES

What kind of work do you do: ____

Who is your main support person (partner, spouse, friend):________________________

Do you consider yourself healthy: ☐ Yes ☐ No

Do you currently smoke: ☐ Yes ☐ No

Have you ever smoked: ☐ Yes ☐ No

Starting at what age: _________

Ending at what age: __________ How many packs a day: _____________

How many glasses of beer, wine or alcohol do you drink every week: _____________

MD Signature:________________________________ Date: __________________

Name: ____________________________________ Visit Date:_______________

Review of Systems

Do you have any of the following?

Constitutional
_____ Weight loss
_____ Weight gain
_____ Fever

Eyes
_____ Vision changes
_____ Glasses/contact lenses

Ear, nose and throat
_____ Sinus problems
_____ Headache
_____ Hearing problems

Respiratory
_____ Wheezing
_____ Shortness of breath
_____ Chronic cough

Cardiovascular
_____ Shortness of breath when lying down
_____ Chest pain
_____ Difficulty breathing on exertion
_____ Swelling in legs and/or feet
_____ Rapid or irregular heartbeat

Genitourinary
_____ Abnormal vaginal bleeding
_____ Painful periods
_____ Premenstrual syndrome (PMS)
_____ Painful intercourse
_____ Abnormal vaginal discharge
_____ Bulge or pressure in the vagina (Prolapse)
_____ Pain with urination
_____ Strong urgency to urinate
_____ Frequent urination
_____ Incomplete emptying
_____ Involuntary loss of urine

Neurological
_____ Fainting spells
_____ Seizures
_____ Numbness
_____ Memory problems
_____ Trouble walking

Hematologic/Lymphatic
_____ Easy bruising
_____ Cuts that do not stop bleeding
_____ Enlarged lymph nodes (glands)

Gastrointestinal
_____ Frequent diarrhea
_____ Constipation
_____ Bloody stools

Musculoskeletal
_____ Muscle weakness
_____ Muscle or joint pain
_____ Low back pain

Skin
_____ Rash
_____ Sores
_____ Moles (new or changed)

Breasts
_____ Pain in breast
_____ Nipple discharge
_____ Lumps

Psychiatric
_____ Depression
_____ Anxiety
_____ Frequent Crying

Endocrine
_____ Hair loss
_____ Heat or cold intolerance
_____ Abnormal thirst
_____ Hot flashes

MD Signature:____________________________________ Date: ____________________