Initials _____ Date of Birth _____

Urogynecology New Patient Intake

Your Name: _____ Today's Date: _____

Your Age: _____

Main reason for your visit:_____

Please answer the following questions:

1. How long has this been going on? □ Less than 6 months □ 6 months – 1 year □ 1 -2 years
2. Since your problem started is it ….. □ Getting better □ Staying the same □ Getting worse
3. How often do you experience urinary leakage? (Please check one)
   - ___ Never, I do not leak urine
   - ___ Less than once a month
   - ___ A few times a month
   - ___ A few times a week
   - ___ Every day and/or night
4. How much urine do you lose each time? (Please check one)
   - ___ None, I do not leak urine
   - ___ Drops
   - ___ Small Splashes
   - ___ More
5. Do you leak urine when you leaking with cough/sneeze/laugh/exercise: □ Yes □ No
6. Do you ever leak urine because you can't make it to the bathroom on time? □ Yes □ No
7. Do you have to wear pads to protect against urine leakage? □ Yes □ No
8. Do you ever wet the bed? □ Yes □ No
9. Number of times you wake up at night to urinate (please circle): 1 2 3 4 5
10. Have you ever been on medication for your bladder problems? □ Yes □ No
11. What bladder medications did you take and for how long? _____
12. Is your urine stream: □ continuous □ strong □ variable □ weak
13. Do you feel like you can completely empty your bladder? □ Yes □ No
14. Have you had many urinary/bladder infections? □ Yes □ No
    - If yes, how many in the past year? _____
    - What medications have you taken for these infections? _____
15. Do you notice anything falling or protruding out of the vagina? □ Yes □ No
16. If you have prolapse, do you push it back in to urinate or move your bowels? □ Yes □ No □ n/a
17. How are your bowel movements? □ normal □ constipated □ diarrhea □ variable
18. Do you ever leak stool? □ Yes □ No
19. Are you sexually active? □ Yes □ No
    - If yes, please complete the PISQ-12 questionnaire
20. Do you have vaginal dryness? □ Yes □ No
21. Do you have any pain with intercourse? □ Yes □ No
22. Are you: □ not in a relationship at present □ have a partner □ married □ widowed
23. Would you like to discuss sexual issues today? □ Yes □ No

Have you had any of the following conditions in the past 6 months – either daily or sporadically?

Constitutional
- ☐ Fever or Chills
- ☐ Unintended weight loss

Cardiovascular
- ☐ Chest pain
- ☐ Heart Palpitations

Respiratory
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Chronic or frequent cough

Endocrine
- ☐ Diabetes
- ☐ Hot flushes
- ☐ Excessive eating

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Difficulty swallowing
- ☐ Heartburn

Genitourinary
- ☐ Burning with urination
- ☐ Blood in urine
- ☐ Kidney or bladder stones

Blood/Lymph
- ☐ Swollen glands
- ☐ Bleeding problems

Skin
- ☐ Rash/Hives
- ☐ Changes in moles
- ☐ Non-healing sores on skin or in mouth

Psychiatric
- ☐ Depression
- ☐ Nervousness
- ☐ Difficulty sleeping

Neurological
- ☐ Frequent or severe headaches
- ☐ Muscle weakness
- ☐ Blurry vision
- ☐ Tingling/ numbness
- ☐ Dizziness
- ☐ Fainting (loss of consciousness)

Please list your medical history / problems:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

List all the surgeries you've had and date (please include cesarean sections and plastic surgery)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

GYN and Pregnancy History:

Number of vaginal deliveries: _____ Were forceps used? _____ Any tear into the rectum? _____
Number of C-Sections: _____ Weight of your largest baby _____
Do you still get periods? ☐ Yes ☐ No
If you still have periods, what is the date of your last period? _____
If you stopped having periods, how old were you when you had your last period? _____
Is there any chance you could be pregnant? ☐ Yes ☐ No
Do you ever have irregular bleeding or spotting from the vagina? ☐ Yes ☐ No

Any difficulty getting pregnant ? IVF _____
Date of last pap smear: _____ Was it normal? ☐ Yes ☐ No

Have you ever had an abnormal pap smear? ☐ Yes please explain: _____ ☐ No

List all medications that you take and the dose:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you **allergic** to any medications? Y N

Are you allergic to Latex Y N

If yes, please list allergies and what happens:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Health Maintenance/Screening:

Date of your last mammogram: _____ Was it normal? Y N

Date of your last colonoscopy: _____ Was it normal? Y N

Social History:

Who do you live with? _____

Do you work outside of your home?	Y N	If yes, please list profession:	_____
Do you smoke cigarettes?	Y N	If yes, how many per day?	_____
Do you drink alcohol?	Y N	If yes, how much per day/week?	_____
Any other recreational substances	Y N	If yes, please list:	_____
Do you exercise on a regular basis?	Y N	If yes, how often per week?	_____

Family History: Does anyone in *your family* have any of the following conditions?

Uterine Cancer	Y	N	Colon Cancer	Y	N	Blood Clots	Y	N
Ovarian Cancer	Y	N	Breast Cancer	Y	N	Prolapse	Y	N
Cervical Cancer	Y	N	Diabetes	Y	N			
Bladder Cancer	Y	N	High blood pressure	Y	N	other_____		

Please list any health problems with your children:_____

Patient Signature:_____ **Date:_____**