GRAND VIEW HEALTH

UROGYNECOLOGY
New Patient History

MRN: _____ Name: _____ Today's Date _____

Complaint: _____

Referring Physician: _____ Primary Care Physician: _____

Gynecologist: _____ Do you currently see other specialists? ☐ Yes ☐ No

If yes, list the doctor and specialty: _____

Medical History - check any and all that apply	
☐ Anemia	☐ High Cholesterol
☐ Anxiety	☐ HIV
☐ Asthma or Emphysema	☐ Hypertension
☐ Blood clots	☐ Kidney Disease - type _____
☐ Bowel Disease - type _____	☐ Liver Disease - type _____
☐ Cancer - type _____	☐ Osteoporosis or Osteopenia
☐ Depression	☐ Rheumatoid Arthritis
☐ Diabetes	☐ Stroke
☐ Frequent Bronchitis	☐ Thyroid Disease - type _____
☐ Glaucoma	☐ Other _____
☐ Headaches	☐ Other _____
☐ Heart Burn or reflux	☐ Other _____
☐ Heart Disease - type _____	
☐ Hepatitis - type _____	

Social History	
Present amount of tobacco use _____ packs per day	Present alcohol intake _____ glasses per week
How long have you been smoking? _____	Prior alcohol use? ☐ Yes ☐ No
Did you smoke in the past? ☐ Yes ☐ No	Illicit drug use? ☐ Yes ☐ No
If yes, how much? _____	History of sexual abuse? ☐ Yes ☐ No
How many years total? _____	History of domestic abuse? ☐ Yes ☐ No
Marital status:	Employment Status:
☐ Married ☐ Single ☐ Widowed	☐ Employed ☐ Unemployed ☐ Retired
	Occupation:

Fall Risk Assessment	
Do you walk unassisted? ☐ Yes ☐ No	Have you fallen in the last year? ☐ Yes ☐ No
Do you use a cane? ☐ Yes ☐ No	Do you feel unsteady on your feet? ☐ Yes ☐ No
Do you use a walker? ☐ Yes ☐ No	Do you use a wheelchair? ☐ Yes ☐ No

Obstetrical and Gynecological History	
Age of onset of First Period _____	Year of Last Pap Smear _____
Date of Last menstrual Period _____	History of Abnormal Pap? ☐ Yes ☐ No
Periods: ☐ Regular ☐ Irregular	History of Hormone Therapy? ☐ Yes ☐ No
Heavy or Painful Periods? ☐ Yes ☐ No	☐ Oral ☐ Patch ☐ Vaginal
Sexually active? ☐ Yes ☐ No	History of? ☐ Ovarian Cysts ☐ Fibroids
Sexually Transmitted Diseases? ☐ Yes ☐ No	# of Pregnancies _____
Bleeding with Intercourse? ☐ Yes ☐ No	# of Live births _____
Pain with Intercourse? ☐ Yes ☐ No	# of Miscarriages _____
Age at Menopause? _____	# of Abortions _____
Postmenopausal Bleeding? ☐ Yes ☐ No	Largest Birth Weight? _____
	Circle all that apply:
	History of forceps / Vacuum assisted delivery /
	Episiotomy / Perineal laceration /
	Birth related pelvic injury

Surgical History

Any History of Pelvic Surgery? Month/Year _____ Procedure _____

Any History of (Circle all that apply)? Urethral / Bladder / Bowel / Gynecologic Surgery

Month/Year _____ Procedure _____

History of Hysterectomy? ☐ Yes ☐ No If yes: ☐ Total ☐ Partial (Ovaries and tubes conserved)

Month/Year _____ Route (circle) Vaginal / Laparoscopic / Open Abdominal / Robotic

History of Tubal Litigation? ☐ Yes ☐ No

History of Urological Surgery? (circle) Kidney / Ureter / Bladder / Urethra Month/Year _____

Procedure _____

Incontinence Surgery? ☐ Yes ☐ No Month/Year _____ Procedure _____

Other Surgery: Month/Year _____ Procedure _____

Other Surgery: Month/Year _____ Procedure _____

Other Surgery: Month/Year _____ Procedure _____

Other Surgery: Month/Year _____ Procedure _____

Family History - Check all that apply

☐ Unknown		☐ Cancer - bladder	Relation _____
☐ Asthma	Relation _____	☐ Cancer - breast	Relation _____
☐ Blood Clots	Relation _____	☐ Cancer - cervical	Relation _____
☐ Diabetes	Relation _____	☐ Cancer - colon	Relation _____
☐ Heart Disease	Relation _____	☐ Cancer - uterine	Relation _____
☐ High Cholesterol	Relation _____	☐ Cancer - liver	Relation _____
☐ Hypertension	Relation _____	☐ Cancer - lung	Relation _____
☐ Liver Disease	Relation _____	☐ Cancer - ovarian	Relation _____
☐ Seizures	Relation _____	☐ Cancer - pancreatic	Relation _____
☐ Stroke	Relation _____	☐ Cancer - prostate	Relation _____
☐ Thyroid Disorder	Relation _____	☐ Cancer - kidney	Relation _____
☐ Bleeding Disorder - Type? _____	Relation _____	☐ Cancer - other _____	Relation _____
☐ Bowel Disease - Type? _____	Relation _____	☐ Cancer - other _____	Relation _____

REVIEW OF SYSTEMS

Review of systems - please check all that apply

General	HEENT	Cardiovascular	Endocrine	Respiratory
☐ Fatigue	☐ Headaches	☐ Chest Pain	☐ Heat/Cold Intolerance	☐ Chills
☐ Fever	☐ Difficulty hearing	☐ Fainting spells		☐ Cough
☐ Weight Gain	☐ Ringing in ears	☐ Heart Palpitations	☐ Loss of hair	☐ Coughing up blood
☐ Weight Loss	☐ Vertigo (dizziness)	☐ Murmur		☐ Wheezing
	☐ Vision problems	☐ Shortness of breath		

Review of systems - please check all that apply

Hematology/Lymph	GI	GU	Musculoskeletal	Neurological
☐ Easy Bruising	☐ Abdominal Pain	☐ Blood in Urine	☐ Back Pain	☐ Headache
☐ Enlarged Glands	☐ Blood in stool	☐ Burning with urination	☐ Joint Pain	☐ Loss of Strength
☐ Gums bleeding easily	☐ Constipation	☐ Painful Urination	☐ Joint Swelling	☐ Memory Loss
	☐ Diarrhea	☐ Urine Incontinence	☐ Muscle Pain	☐ Numbness
	☐ Fecal Incontinence	☐ Vaginal Bleeding	☐ Muscle Weakness	☐ Tremors
	☐ Heartburn/Reflux	☐ Vaginal Discharge	☐ Stiffness	
	☐ Nausea			
	☐ Vomiting			

Bladder Habits

of voids per day _____

# of times you wake up at night to void _____

#of episodes of urgency per day _____

# of leaks with urgency per day _____

# of leaks with laugh, cough or sneeze per day _____

# of leaks with exercise, lifting, bending over _____

Which is more bothersome - leakage with activities or with urge? Or are they equally bothersome?

_____

Perform Kegal exercises? ☐ Yes ☐ No

Prior pelvic floor rehab or biofeedback? ☐ Yes ☐ No

Any prior overactive bladder or bladder control medications:

Circle all that apply:

Detrol LA / Ditropan XL / Oxybutynin /

Oxytrol Patch / Sanctura (Trospium) /

Toviaz / Imipramine / Enablex /

Myrbetriq / Vesicare / Flomax /

Estrogen cream

Any help? ☐ Yes ☐ No

Side effects? ☐ Yes ☐ No

Which ones? _____

# of pads used to stay dry per day _____

# of leaks without activity or sensation _____

Leakage with Intersourse ☐ Yes ☐ No

Bedwetting ☐ Yes ☐ No

# of sugar substitutes used per day _____

# of caffeinated drinks per day _____

# of carbonated drinks per day _____

Hesitancy to start urinating ☐ Yes ☐ No

Straining to maintain flow ☐ Yes ☐ No

Dribbling after urinating ☐ Yes ☐ No

Urine stream **(Circle what applies)**

Slow / Interrupted / Strong

Incomplete bladder emptying? ☐ Yes ☐ No

Bowel Habits

How often do you move your bowels? **Circle all that apply:**

Daily / Every other day / _____ per week

Bowel Consistency **(Circle)**

Formed / Hard / Soft / Loose / Liquid

History of constipation? ☐ Yes ☐ No

Excessive straining with bowel movement? ☐ Yes ☐ No

Incomplete bowel emptying? ☐ Yes ☐ No

Do you use: **Circle all that apply:**

Supplemental fiber / stool softeners / laxative

Prior use of Imodium or Lomotil ☐ Yes ☐ No

History of rectal surgery? ☐ Yes ☐ No

Month/year _____

Procedure _____

Year of last colonoscopy (if applicable) _____

Findings? _____

Fecal Incontinence? ☐ Yes ☐ No

If yes circle all that apply:

Loose / liquid / solid stool / flatus

How many episodes per week? _____

Prior Treatment for Incontinence? ☐ Yes ☐ No

Circle all that apply:

Surgery / Fiber / Lomotil / Imodium

Pelvic floor rehab / Biofeedback

Bladder / Pelvis Assessment

Lower Urinary Tract Symptoms: **Circle all that apply:**

Gross Hematuria (Blood in Urine) / Dysuria /

Burning with urination / Pain with full bladder /

Urinary odor / Cloudy urine

Last Urinary Tract Infection? _____

How many Urinary Tract Infection in last 6 months? _____

In the last year? _____

Prior antibiotics used? _____

Prior long term antibiotics used? ☐ Yes ☐ No

Suppression for several weeks / months? _____

Pelvic Pain: Location _____

Circle all that apply:

Sharp / Stabbing / Throbbing / Cramps

What makes pain worse? _____

What makes pain better? _____

Is pain constant or comes and goes? _____

Prior treatments: **Circle all that apply:**

Elavil / Elmiron / Pudendal blocks /

Bladder instillation / Neurontin / Narcotics /

NSAIDs / Physical therapy / Pyridium

Uribel / Cystoscopy / Hydrodistention /

Vaginal Valium / Muscle relaxant

Pelvic Organ Prolapse: **Circle all that apply:**

Pelvic pressure / Heaviness sensation / Dullness sensation

Vaginal bulge seen or palpable or visible bulge /

Support to vagina, rectum or perineum to complete a bowel movement or urination

Prior pessary treatment? ☐ Yes ☐ No

If yes, type? _____

Prolapse Surgery? ☐ Yes ☐ No

Sexual dysfunction (if sexually active)

Pain with intercourse? ☐ Yes ☐ No

Pain on entry or deep pain? ☐ Yes ☐ No

Urinary incontinence with intercourse? ☐ Yes ☐ No

Bowel incontinence with intercourse? ☐ Yes ☐ No

Avoidance of sexual relations due to? **Circle all that apply:**

Pain / Prolapse /

Incontinence of urine or bowel /

Vaginal dryness

Lack of interest in sexual intimacy? ☐ Yes ☐ No

If yes, why? _____