Grand View Medical Practices Urogynecology

Name: _____ **Date of Birth:** _____

Reason for Today's Visit: _____

Primary Care Physician: _____ **Gynecologist:** _____

Do you currently see other Specialists?: (please list) _____

Do you feel safe at home?: Circle one: Yes No
Preferred Laboratory?: Circle one: Grand View LabCorp Quest Other:_____
Preferred Pharmacy: _____ **City:**_____ **Phone:**_____
Would you like Access to GVH online Patient Portal?: Circle One: Yes No

Allergies to Medications:

Medication	**Reaction**
_____	_____
_____	_____
_____	_____

Current Medications You Take:

Medication	**Dose**	**Frequency**	**Reason**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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OB/GYN History

Age of onset of first period: _____
Date of last menstrual period: _____
Your periods are (circle one):
Regular Irregular
Age at Menopause: _____
Any Postmenopausal bleeding? _____
Year of last Pap Smear?: _____
History of abnormal pap smear?:
(circle) Yes No

History of Hormone Therapy?: (circle) Yes No
Oral Patch Vaginal/IUD Implant
History of? Ovarian Cysts Fibroids
# of Pregnancies: _____ **# of Live Births**: _____
# of Miscarriages _____ **# of Terminations**: _____
Largest Birth weight: _____
Circle All That Apply: History of Forceps
Episiotomy Perineal Laceration
Vacuum Assisted Delivery Cesarean
Birth Related Pelvic Injury

Past Surgical History

Any history of Hysterectomy?: [ ] Yes [ ] No
If yes: [ ] Total [ ] Partial (ovaries and tubes conserved)
Month/Year: _____
Route (circle one): Vaginal Laparoscopic Open Abdominal Robotic
History of Tubal Ligation?: [ ] Yes [ ] No
Have you had any other type of Pelvic or Urologic Surgery?: [ ] Yes [ ] No
(Circle all that apply): Bladder Bowel Cesarean Section Gynecologic Surgery
Incontinence Kidney Urethra Ureter
If yes, list what procedure and when: _____
_____
_____

Other surgeries not related to urogynecology:

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

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Bladder Habits

How Many Times Per Day Do You:

- Void (urinate): _____
- Wake up at night to void:_____
- Have episodes of urgency: _____
- Have leaks with urgency: _____
- Have leaks with laughing, coughing, or sneezing: _____
- Have leaks with exercise, lifting, or bending over: _____
- Have leaks *without* any activity or sensation: _____

How many pads do you use to stay dry per day?: _____
Any bedwetting at night?: (circle one) Yes No
Any leakage with intercourse?: (circle one) Yes No
Do you have hesitancy to start urinating? (circle one) Yes No
Do you have to strain to maintain flow?: (circle one) Yes No
Do you have any dribbling after urinating? (circle one) Yes No
Do you have difficulty emptying your bladder completely?: (circle one) Yes No
Your urine stream is (circle what applies): Slow Interrupted Strong
Which is more bothersome, leaking with activities or leaking with urge? Or are they equally bothersome? _____

Do you perform Kegel exercises? (circle one) Yes No
Have you had any prior pelvic floor rehab or biofeedback? (circle one) Yes No
Have you used any medication to control overactive bladder? (Circle all that apply)

- Oxybutynin (Ditropan)
- Tolterodine (Detrol)
- Trospium (Sanctura)
- Darifenacin (Enablex)
- Fesoterodine (Toviaz)
- Mirabegran (Myrbetric)
- Vibegron (Gemtesa)
- Solifenacin (Vesicare)
- Estrogen Cream (Estrace)
- Premarin

Any side effects?: _____

How many caffeinated drinks per day?: _____
Number of sugar substitutes per day?: _____
Number of carbonated drinks per day?_____

Lower urinary tract symptoms: (circle all that apply)

- Blood in Urine
- Burning with urinating
- Pain with urinating
- Strong urinary odor
- Pain with full bladder
- Cloudy urine
- Frequent Urination
- Urgency

When was your last urinary tract infection?: _____

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How many urinary tract infections have you had in the last 6 months?:_____
Which medications or treatments have you used in the past to treat them?: (circle all that apply)

- Amoxicillin
- Bactrim
- Macrobid
- Keflex
- Other antibiotic (Explain):_____
- Azo
- Pyridium
- NSAIDs
- Narcotics
- Vaginal Valium
- Cystoscopy
- Physical Therapy
- Pudendal Blocks
- Uribel
- Elmiron

Pelvic organ prolapse? (Circle all that apply)

Pelvic Pressure Heaviness Sensation Vaginal Bulge seen or felt
Dullness Sensation Support to vagina or rectum to complete a bowel movement or urinate

Have you ever used a pessary?:_____ **If yes, what type?**:_____
Do you have pain with intercourse?: **(circle one)** Yes No
If yes, is the pain on entry or deep pain?: _____
Avoidance or lack of interest in sexual relations is due to: (circle all that apply)

Pain Prolapse Vaginal Dryness Incontinence

Bowel Habits

How often do you move your bowels?: (circle what applies)

- Daily
- Every other day
- _____ times per week

Bowel consistency is: (circle what applies)

- Formed
- Hard
- Soft
- Loose
- Liquid

Constipation: (Circle one) Yes No
Excessive Straining?: (Circle one) Yes No
Incomplete Bowel Emptying: (Circle one)
Yes No
Fecal Incontinence?: (Circle one) Yes No
If yes, how many times per week? ____
Any prior treatment for fecal incontinence?:
_____

Do you use any of the following: (circle all that apply)

- Stool Softeners
- Supplemental fiber
- Laxatives
- Physical Therapy
- Biofeedback

Year of last colonoscopy: _____
Findings?: _____
_____

Any history of rectal surgery: (Circle one)
Yes No
Any other previous treatments for fecal incontinence not already mentioned?:
_____
_____