GVH GRAND VIEW HEALTH

Grand View Medical Practices Urogynecology

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

Reason for Today's Visit: _____

Primary Care Physician: _____ **Gynecologyist:** _____

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 Patietn Portal?: Circle One: Yes No

Allergies to Medications:

Medication	Reaction

Current Medications You Take:

Medication	Dose	Frequency	Reason

OB/GYN History

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**
_____	_____
_____	_____
_____	_____
_____	_____

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 with *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)
- ○ Mirabegron (Myrbetriq)
- ○ Vibegron (Gemtesa)
- ○ Solifenacin (Vesicare)
- ○ Estrogen Cream (Estrace)
- ○ Premarin

Any side effects? _____

How many caffeinated drinks per day? _____

Number of alcoholic drinks per day? _____

Number of carbonated drinks per day? _____

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

Prolapse

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 may 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?

_____

_____