

UROGYNECOLOGY

PATIENT IDENTIFICATION

Date _____

Name _____ Sponsor's ssno _____

DOB _____ Age _____ Single Married Separated Divorced Widowed

Race _____ Referring Physician _____

CHIEF COMPLAINT: _____

HISTORY OF PRESENT ILLNESS: _____

PREVIOUS TREATMENT: No Yes (Describe) _____

WORSE SYMPTOMS: Incontinence (Non-specific) Stress Incontinence Urge Incontinence

Frequency Urgency Nocturia Nocturnal Enuresis Dysuria Bladder Pain

Lack of Bladder Sensation Hesitancy Voiding Difficulty (Non-specific) Straining to Void

Poor Flow Intermittent Stream Incomplete Emptying Other: _____

FREQUENCY _____ times/day or every _____ hours. **NOCTURIA** up to _____ times/night

INCONTINENCE Yes No Don't Know N/A

Describe a typical episode: _____

Number of incontinent episodes _____ per day _____ per week _____ per month

Stress incontinence? No Sometimes Often Always Don't Know N/A

Urge incontinence? No Sometimes Often Always Don't Know N/A

Incontinence provoked by: Coughing Laughing Sneezing Lifting Standing Up

Walking Exercise (Type): _____ Running Water

Putting a Key in a Door Sexual Intercourse Other: _____

Typical amount of leakage: Damp Wet Soaked

Worse amount of leakage: Damp Wet Soaked

Do you wear pads for protection? No Yes Sometimes Always

Type: Tissue Only Mini-pads Tampons Regular menstrual pads Heavy incontinence pads

Pads changes _____ per day _____ per week

When you change your pads are they usually: Damp Wet Soaked

Have you changed or restricted your activities because of your bladder leakage? No Yes

Example: _____

Do you wet the bed in your sleep? No Yes – How often? _____

Were you a bed wetter as a child? No Yes – Age at which you stopped: _____

VOIDING DYSFUNCTION:

Hesitancy	Never	Sometimes	Often	Don't Know	N/A
Straining to void	Never	Sometimes	Often	Don't Know	N/A
Poor flow	Never	Sometimes	Often	Don't Know	N/A
Intermittent stream	Never	Sometimes	Often	Don't Know	N/A
Can interrupt stream	Often	Sometimes	Never	Don't Know	N/A
Incomplete emptying	Never	Sometimes	Often	Don't Know	N/A
Post-micturition dribble	Never	Sometimes	Often	Don't Know	N/A
Acute urinary retention	Never	Sometimes	Often	Don't Know	N/A

BLADDER SENSATION:

Aware of fullness?	Yes	No	Don't Know	N/A
Aware of wetness?	Yes	No	Don't Know	N/A
Dysuria?	No	Sometimes	Often	Only with infection
Bladder pain?	No	Sometimes	Often	
Is the pain relieved by voiding?	No	Yes		

INFECTION AND STONES:

Previous UTI?	No	Yes	_____ in past year	Don't Know
Previous pyelonephritis?	No	Yes	Details: _____	
Previous IVP?	No	Yes	Don't Know Findings: _____	
History of kidney stones or urinary bladder stones?	No	Yes	Don't know	
Details:	_____			

HEMATURIA:

Are you passing blood in our urine now?	No	Yes	Sometimes
Details:	_____		

Have you ever passed blood in your urine in the past? No Yes

Details: _____

BOWEL FUNCTION:

Frequency of stool: _____ per day _____ per week _____ per month

Laxatives?	Suppositories?	Enemas?	Manual Pressure?	Disimpaction?
Incontinent of gas?	No	Sometimes	Often	Don't Know
Incontinent of liquid stools?	No	Sometimes	Often	Don't Know
Incontinent of solid stool?	No	Sometimes	Often	Don't Know

Comments: _____

GYNECOLOGIC HISTORY:

Menarche _____ LMP _____ Cycle _____

Comments: _____

Bladder symptoms related to menstrual periods? No Yes: _____

Contraception? No Yes: _____

Hormone therapy? No Yes: _____

Last Pap smear _____ Previous abnormal smears? No Yes: _____

STD? No Yes: _____

SEXUAL FUNCTIONING:

Sexually active? No Widow Yes _____ times/day/week/month

Dyspareunia? No Yes Superficial Deep Both

Incontinent with intercourse? No Yes With penetration With orgasm With both

Have you altered your sexual behavior due to your bladder or prolapse? No Yes: _____

OBSTETRICAL HISTORY:

Vaginal deliveries _____ Forceps _____ Cesarean _____

Significant tears or lacerations? No Yes: _____

FAMILY HISTORY:

Breast cancer? No Yes: _____

Kidney disease? No Yes: _____

Other: _____

PAST MEDICAL HISTORY:

Neurological history? No Yes: _____

Diabetes? No Yes: _____

Chronic Lung Disease? No Yes: _____

Smoker? No Yes: _____ packs/day for _____ years

Alcohol? No Yes: _____

Drug abuse? No Yes: _____

Psychiatric history? No Yes: _____

Previous Mammogram: No Yes: _____

Other: _____

PAST SURGICAL HISTORY:

CURRENT MEDICATIONS:

ALLERGIES:
