Northeast Ohio Urogynecology Patient History Intake Form

Last Name ___________________________First Name _________________________Age______

Date of Birth _________Race _________Referring Physician_____________________________

Reason for Visit: ____

____

____

Allergies: ____

Preferred Lab (circle): QUEST LABCARE PLUS LABCORP OTHER

Pharmacy Name/phone Number:____

Medical History: Which of the following conditions are you currently being treated or have been treated for in the past (please check)?

□ Heart disease / Murmur / Angina	□ Shortness of breathe	□ Eye disorder / Glaucoma
□ Diabetes	□ High cholesterol	□ Asthma
□ Kidney / Bladder problems	□ Seizures	□ High blood pressure
□ Lung problems / cough	□ Stroke	□ Liver problems / Hepatitis
□ Blood Clot	□ Sinus problems	□ Headaches /Migraines
□ Arthritis	□ Heartburn (reflux)	□ Seasonal allergies
□ Neurological problems	□ Cancer	□ Anemia or blood problems
□ Tonsillitis	□ Depression / Anxiety	□ Ulcers/colitis
□ Swollen ankles	□ Psychiatric care	□ Thyroid problems

Past Surgical History:

□ Hysterectomy	Date:___________	Incision:	□ Abdominal	□ Vaginal
□ Bladder Sling	Date:___________	Type:	□ Mesh	□ Fascial/Cadaveric
□ Prolapse Surgery	Date:___________	Type:	□ Mesh	□ Non-mesh
□ Major Abdominal	Date:___________	Reason: ______________________________		
□ Laparoscopic Abdominal	Date:___________	Reason: ______________________________		
□ Other	Date:___________	Reason: ______________________________		
□ Other	Date:___________	Reason: ______________________________		
□ Other	Date:___________	Reason: ______________________________		
□ Other	Date:___________	Reason: ______________________________		

OB/GYN History:

# of pregnancies:________ # of vaginal births:________ # of C-sections:________

□ Premenopausal □ Peri-menopausal □ Menopausal

Do you use hormone replacement?

□ Oral contraception □ Oral HRT □ Vaginal estrogen

Social History:

□ Alcohol	□ Drugs	□ Cigarettes
□ Single	□ Married	□ Divorced

Family History:

□ Cancer	□ Bleeding Disorders	□ Heart Disease
□ Diabetes	□ Hypertension	□ Other_______________________

Name____________________________

Date____________________________

Northeast Ohio Urogynecology Patient Medication List

Please write down all of your medications below or provide an attached list.

Prescription Medications		Over-the-Counter Medications	
Name	Dose	Name	Dose

Northeast Ohio Urogynecology Reveiew of Systems

Name______________________________

Date______________________________

General/Constitutional

□ Appetite
□ Fatigue
□ Fever
□ Weight change

HEENT/Neck

□ Change in vision
□ Hearing loss
□ Nasal congestion
□ Hoarseness
□ Sore throat

Endocrine

□ Cold intolerance
□ Excessive thirst
□ Excessive urination
□ Heat intolerance

Respiratory

□ Chronic Cough
□ Shortness of breath
□ Wheezing

Cardiovascular

□ Chest pain
□ Leg Swelling
□ Palpitations
□ Varicose veins

Gastrointestinal

□ Abdominal Pain
□ Bloating
□ Blood in Stool
□ Change in Bowel Habits
□ Heartburn
□ Incontinence of Stool
□ Nausea
□ Vomiting

Hematology

□ Anemia
□ Easy bleeding
□ Easy bruising

Women Only

□ Vaginal Dryness
□ Low libido
□ Pain with sex
□ Heavy periods
□ Hot Flashes
□ Irregular periods

Genitourinary

□ Blood in urine
□ Burning on urination
□ Urinary tract infections
□ Urinary Incontinence
□ Vaginal discharge
□ Vaginal Pressure/Bulge

Musculoskeletal

□ Back pain
□ Joint pain
□ Joint stiffness
□ Muscle pain
□ Tingling/numbness

Neurologic

□ Confusion
□ Dizziness
□ Headache
□ Seizure

Mental Health

□ Anxiety
□ Depression
□ Sleep Disturbances

Name______________________________

Date_______________________________

Pelvic Floor Symptom Survey

Instructions: Please answer all of the questions in the following survey. Answer these by circling the appropriate number. While answering these questions, please consider your symptoms over the **last 3 months**.

Symptoms Present = YES: 1 = not at all, 2 = somewhat, 3 = moderately, 4 = quite a bit
Not Present = NO: 0 = not presents

Pelvic Organ Prolapse Symptoms

Do you....	No	Yes
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1 2 3 4

Bowel Symptoms

Do you....	No	Yes
7. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
9. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
10. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
11. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
12. Usually have pain when you pass your stool?	0	1 2 3 4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1 2 3 4

Urinary Symptoms

Do you....	No	Yes
15. Usually experience frequent urination?	0	1 2 3 4
16. Usually experience urine leakage associated with it feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	1 2 3 4
17. Usually experience urine leakage related to coughing, sneezing, or laughing?	0	1 2 3 4
18. Usually experience small amounts of urine leakage (that is, drops)?	0	1 2 3 4
19. Usually experience difficulty emptying your bladder?	0	1 2 3 4
20. Usually experience pain or discomfort in the lower abdomen or genital region?	0	1 2 3 4

Northeast Ohio Urogynecology Sexual Function Questionnaire

Are you currently sexually active?

- **No.** Please circle reason:

  I am not able   I have too much pain   I have no desire

  I do not have a partner   My partner is not able

- **Yes.** Proceed with next 12 questions

1. Do you feel pain during sexual intercourse?

   Always   Usually   Sometimes   Seldom   Never

2. Are you incontinent of urine (leak urine) with sexual activity?

   Always   Usually   Sometimes   Seldom   Never

3. Does fear of incontinence (either stool or urine) restrict you sexual activity?

   Always   Usually   Sometimes   Seldom   Never

4. Do you avoid sexual intercourse because of bulging of the vagina (either bladder, rectum, or vagina falling out?)

   Always   Usually   Sometimes   Seldom   Never