Southern Urogynecology
Center for Incontinence and Female Pelvic Medicine

Patient Health Questionnaire

Name____Age______________ Date of Birth: ___/___/______
Primary MD: ____Phone: ___________________________
Referring MD: ____Phone: ___________________________

Pharmacy: ______________________________ Rd: _______________________City: ____________________

Chief Complaint/History of Present Illness: Please **check all that apply**

	Stress Incontinence(leaking urine when you laugh, cough, sneeze		Incomplete Emptying (Difficulty emptying your bladder-may sit on the toilet and wait for a long time)		Chronic Interstitial Cystitis
	Urge Incontinence (run to the bathroom and can not hold urine before reaching the toilet)		Pelvic Heaviness (heaviness or bulging in vagina or pelvic area		Urinary Retention (unable to empty the bladder)
	Frequency (Frequent urination)		Prolapse		Back/Flank Pain
	Nocturia (Nightly excessive voiding-waking up at least 2 times to void during the night)		Fecal incontinence (unable to control bowel movements)		Pain or burning when voiding
	Nocturia (Nightly excessive voiding – waking up 3 or more times to void during the night)		Recurrent UTI's (urinary tract infections)		Constipation
	Enuresis (Episodes of wetting the bed)		Cystocele		Diarrhea
	Episodes of waking up in the morning and as soon as your feet hit the floor you leak or wet.		Chronic hematuria (blood in urine)		Other:

How long have you experienced these issues? ____
Does anything seem to make the issue better? ____
Do you wear pads? _______ YES ________NO If so how many a day? _____________
Are you currently sexually active? _________ Yes _________ No Do you feel pain during intercourse? ___________ Yes ___________ No
Do you have urinary leakage during intercourse? ___________ Yes ____________ No
Have you ever been physically, sexually or emotionally abused? __________ Yes __________ No

Past Medical History: **Please indicate whether you are currently being treated for or have been treated for any of these conditions in the past.**

	Diabetes		Dementia		Asthma		Anemia
	Hypertension		Parkinson's		Atrial Fibrillation		Osteoporosis
	Stroke		Fibromyalgia		Lung Disease /Pneumonia		Tuberculosis
	Head Injury		Arthritis		Stomach Problems/Ulcers		Lupus
	Epilepsy or Convulsions		GERD		Colitis		Phlebitis
	High Cholesterol		Gall Bladder Disease		Irritable Bowel Syndrome		Thrombosis
	Hyperthyroidism		Heart Disease		Gout		Migraine Headaches
	Hypothyroidism		Heart Murmur		Kidney Stones		Cancer:
	Alzheimer's		Mitral Valve Prolapse		Hernia		Other:

Urogynecology Surgery ______I have not had any previous Urogyn surgical procedures.
Please indicate whether and when you have had any of the following surgeries. Use last box in each category to indicate any surgeries not listed.

Surgery	Date	Surgeon	Surgery	Date	Surgeon
None			Vaginal Mesh		
Bladder Sling			Vaginal Hysterectomy		
Anterior Repair			Abdominal Hysterectomy		
Posterior Repair			Laparoscopic Hysterectomy		
"Bladder Tack"			Intracystic Botox Injection		
Burch Colposuspension			Urethral Dilation		
InterStim			Mesh Removal /Revision		
Urethral Bulking			Perineorraphy		
Cystoscopy			Tubal Ligation		
Cysto w/Hydrodistension			Bilateral Oophorectomy		
Colpopexy			Laparoscopic Sacrocolpopexy::		

Past General Surgical History ______ **I have not had any previous surgical procedures.**

Please indicate whether and when you have had any of the following surgeries. Use last box in each category to indicate any surgeries not listed.

	Gallbladder		Appendectomy		Mastectomy		Thyroid Removal
	Tonsillectomy		Knee Surgery		Brain Surgery		Bariatric Surgery
	Adenoidectomy		Colon/GI Surgery		Lumpectomy		Stent Placement
	Shoulder Surgery		Hip Surgery		Colon resection		Other:
	Heart Surgery		Back /Spinal Surgery		Hernia Repair		Other:

Previous GYN History: **Please indicate whether and when you have had any of the following conditions/procedures. Use last box in each category to add those not listed.**

	Ablation		Laparoscopy for Endometriosis		Ovarian Cancer		Total Vaginal Hysterectomy
	Abnormal Pap Test		Laparoscopic lysis of adhesions		Ovarian Cysts		Menopause
	Bilat Tubal Ligation		Laparoscopic removal of tubes and ovaries (left side)		Partial hysterectomy		Breast Cancer
	D&C		Laparoscopic removal of tubes and ovaries (right side)		Removal of ovaries		Cervical Cancer
	Endometriosis		Other Laparoscopic Proced:		Supra Cervical Hysterectomy		Menorrhagia (heavy periods
	Fibroids		Microwave Endometrial Ablation		Total Abdominal Hysterectomy		Total Laparoscopic Hysterectomy

OB History: # of Children: ___________ # of Vaginal Deliveries: _____________ # of Caesarean Deliveries ____________

# of Miscarriages:_____________ # of Voluntary Terminations:_____________

Complications:____

STD Infection History: _______ **I have no history of STD's or Infection**

	Herpes		Syphilis
	Hepatitis B		Gonorrhea
	Hepatitis C		Condylona (genital warts)
	Chlamydia		Other

Non-Surgical GYN Medications/Treatments Previously Tried: **(Please check those that apply and indicate dosing)**

✓	**MEDICATION**	Mg/Dose	✓	**MEDICATION**	Mg/Dose	✓	**MEDICATION/THERAPY**	Mg/Dose	✓
	Amitriptyline			Gelnique			Osphena		
	Detrol LA			Imipramine			Linzess		
	Diazepam			Myrbetriq			Aloe Vera Caps		
	Ditropan			Oxybutinin			Ellura		
	Elavil			Sanctura			Pessary		
	Elmiron			Toviaz			Bladder Instillations		
	Enablex			Uribel			Kegels		
	Flomax			Vesicare			E-Stim or Interstim		
	Estrace			Premarin			Physical Therapy		

Family History **Please indicate whether anyone in your family has had the following conditions including mother, father, sister, brother, grandfather or grandmother.** ________ **I am adopted and I do not know my family medical history.**

✓	Condition	Family Member	✓	Condition	Family Member
	Bladder Cancer			Colon/Other GI Cancer	
	Interstitial Cystitis			Breast Cancer	
	Urinary Incontinence			Other Cancer:	
	Kidney Stones			Heart Disease	
	Kidney Failure			Diabetes:	
	Ovarian Cancer			Other Disease:	

Personal/Social History: Please complete the following:

Marital Status : _________ Single __________Widowed _________Married

_________ Separated __________Divorced _________Other

Children: _____________ Living At Home: ____________

Out of the Home: _____________

Alcohol Consumption: ________None ________Rarely _______Social _______1-2 Drinks Daily/Weekly

________Alcohol ________Beer _______Wine _______3+ Drinks Daily/Weekly

Tobacco Use: ________None ________Rarely _______Previous Smoker How many years quit? ________________

________Cigarettes ________Smokeless Tobacco

________Current Smoker: ________less than ¼ pack/day _______1/4 pack/day _____1/2 pack day

________ 1 pack day/week _______2 or more packs day/week

Street Drugs Used: _______None ________Marijuana _______Cocaine

_______Crack ________IV drug use _______Other

Smoking Cessation Counseling: _____ No _____ Yes

Caffeinated Beverages: ______None ________Rarely _______Occasionally

______Daily ________Weekly _______Coffee ______Tea

_______Soda ______Other

#______ Of Beverages per Day

Exercise: _______None ____1 day/wk ____2-3 days/wk ____over 3 days/wk

Type of Exercise: _______Running _____Walking _______Swimming _______Biking

_______Aerobics _____Tennis ________Golf _______Roller blading

_______Weight lifting _____Horseback riding _______Scuba diving

_______Yoga Other: ________________________

I have completed the Universal Medication list and this Medical Questionnaire to the best of my knowledge and ability. Southern Urogynecology will not be held responsible for any missing or incorrect information.

Patient Signature____ Date ____

Reviewed by MD:____ Date:__________________________________