



Northside Center FOR UROGYNECOLOGY

A Northside Network Provider

APR 18 2015 10:00 AM

NEW PATIENT QUESTIONNAIRE

Name: _____

Date of Birth: _____

Referring Provider: _____

Gynecologist: _____

Primary Care Provider: _____

Please list all of your other medical providers and their specialty:

Please briefly summarize your main health concern for today's visit.

How long have you had your most bothersome problem?

What is your main goal for today's visit?

PELVIC FLOOR DISTRESS INVENTORY

Please answer all of the questions in the following survey. These questions will ask if you have certain bowel, bladder, or pelvic symptoms and, if you do, how much they bother you. Answer these by placing an "X" in the appropriate box or boxes. While answering these questions please consider your symptoms of the last three months.

Pelvic Organ Prolapse Distress Inventory	NO	YES	If YES, how much does it BOTHER you?			
			Not at all	Some-what	Moder-ately	Quite a bit
Do you.....						
Usually experience pressure in the lower abdomen?						
Usually experience heaviness or dullness in the pelvic area?						
Usually have a bulge or something falling out that you can see or feel in your vagina?						
Ever have to push on the vagina or around the rectum to complete a bowel movement?						
Ever have to push up on a bulge in the vagina with your fingers to start or complete urination?						
Colorectal-Anal Distress Inventory						
Feel you need to strain too hard to have a bowel movement?						
Feel you have not completely emptied your bowels at the end of a bowel movement?						
Usually lose stool beyond your control if your stool is well-formed?						
Usually lose stool beyond your control if your stool is loose?						
Usually lose gas from the rectum beyond your control?						
Usually have pain when you pass stool?						
Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?						
Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?						
Urinary Distress Inventory						
Usually experience frequent urination?						
Usually experience urine leakage associated with a feeling of urgency (a strong sensation of needing to urinate)?						
Usually experience urine leakage related to coughing, sneezing, or laughing?						
Usually experience small amounts of urine leakage (drops)?						
Usually experience difficulty emptying your bladder?						
Usually experience pain or discomfort in the lower abdomen or genital region?						

NEW PATIENT QUESTIONNAIRE

Urinary Stress Symptoms	Never	Rarely	Some-times	Often
Does coughing gently cause you to lose urine?				
Does coughing hard cause you to lose urine?				
Does sneezing cause you to lose urine?				
Does lifting things cause you to lose urine?				
Does bending cause you to lose urine?				
Does laughing cause you to lose urine?				
Does brisk walking or jogging cause you to lose urine?				
Does straining, if you are constipated, cause you to lose urine?				
Does getting up from a sitting to a standing position cause you to lose urine?				
Urinary Urge Symptoms				
Some women receive very little warning and suddenly find they are losing, or are about to lose urine beyond their control. How often does this happen to you?				
If you can't find a toilet or find that the toilet is occupied, and you have an urge to urinate, how often do you end up losing urine or wetting yourself?				
Do you lose urine when you suddenly have the feeling that your bladder is very full?				

How often do you typically urinate during the day? Every ____ hours, _____ # times per day.

How often do you urinate during the night after going to bed? _____ # times per night.

Do you TYPICALLY have pain or burning when you urinate? NO YES

Do you TYPICALLY have pain when your bladder is full? NO YES

If so, does the pain resolve when you empty? NO YES

Do you leak urine? NO YES

Typically, how many times do you leak urine during the daytime? _____ times per DAY WEEK MONTH

In the last month, how many times have you wet the bed at night? _____ times per DAY WEEK MONTH

Do you wear protection for urine loss? NO YES

When you change your pads, are they.. DRY HAVE A FEW DROPS WET SOAKED

Use the following table to indicate how many of the following pads you use during the day and night.

	Tissue	Mini-Pad/Liner	Regular Pad	Heavy/Diaper
DAYTIME				
NIGHT TIME				

NEW PATIENT QUESTIONNAIRE

Bowel Symptoms

How many bowel movements do you typically have each week? _____

Do you have trouble with constipation? NO YES

Do you have trouble with diarrhea? NO YES

Do you have accidental bowel leakage? NO YES

In a typical month, how often do you have accidental bowel leakage? _____ times per month

Do you use pads or devices for bowel leakage? NO YES, _____ per day

Sexual Function

Pelvic floor problems often interfere with sexual relations. In order to best treat you, it is important to ask questions about your sexual health. If you feel uncomfortable answering these questions prior to your appointment, please discuss these issues with Dr. Tugbiyele at the time of your initial visit.

Is your sex life satisfactory for you? NO YES

Are your sexual activities limited by your pelvic floor problem? NO YES

Are you sexually active at this time in your life? NO YES

If you answered "NO", then you can skip the additional questions.

Does your sexual activity include vaginal intercourse? NO YES

During intercourse, when do you leak urine? Never With Penetration With Orgasm

When do you have pain with intercourse? Never With Deep Penetration With Entry

Health Maintenance

Please provide the date and results of your last screening exams. If abnormal, please describe findings.

Pap Smear _____ Normal Abnormal _____

Mammogram _____ Normal Abnormal _____

Colonoscopy _____ Normal Abnormal _____

Bone Density _____ Normal Abnormal _____

NEW PATIENT QUESTIONNAIRE

Obstetric and Gynecologic History

No. of Pregnancies: _____ Vaginal deliveries: _____ Cesarean births: _____ Miscarriages/Abortions _____

What is the weight of your largest baby born vaginally? _____ pounds _____ ounces

Have you ever had forceps or a vacuum used with delivery? NO YES

Have you suffered a severe tear after delivery that involved the anal sphincter/rectum? NO YES

Have you gone through menopause? NO YES CURRENTLY UNSURE

If NO: Are you using contraception? NO YES

If YES: Please list _____

If YES, have you completed having children? NO YES

If YES: At what age did you go through menopause? _____ years

Did you or do you currently use hormone replacement therapy (including vaginal)? NO YES

Do you have a history of abnormal pap smears? NO YES

Treatment History

Have you had prior treatment for pelvic prolapse, urinary, or bowel problems? NO YES

If you answered "NO", then you may skip the rest of this section.

Have you tried pelvic muscle (Kegel) exercises or pelvic floor physical therapy? NO YES

If yes, did it help? NO YES

Please identify any medications you have tried or are currently taking.

- | | |
|---|--|
| <input type="checkbox"/> Darifenacin (Enblix) | <input type="checkbox"/> Oxybutynin (Ditropan, Ditropan XL, Oxytrol patch, Gelnique) |
| <input type="checkbox"/> Tolterodine (Detrol) | <input type="checkbox"/> Fesoterodine (Toviaz) |
| <input type="checkbox"/> Solifenacin (Vesicare) | <input type="checkbox"/> Trospium (Sanctura) |
| <input type="checkbox"/> Mirabegron (Myrbetriq) | <input type="checkbox"/> Other: _____ |

If you previously took any of these medications, why did you stop? SIDE EFFECTS DIDN'T HELP

Have you tried a pessary or vaginal device? NO YES

If yes, did it help? NO YES

NEW PATIENT QUESTIONNAIRE

Medical History – Please mark with an X if you have any of the following medical conditions

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heart attack | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Recurrent urinary tract infections |
| <input type="checkbox"/> Anticoagulation therapy | <input type="checkbox"/> Pelvic radiation | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Neurologic disease | <input type="checkbox"/> Back injury | <input type="checkbox"/> Hypothyroid |
| <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Back pain or sciatica | <input type="checkbox"/> Jehova’s witness/refuse blood products |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Liver disease | |
| <input type="checkbox"/> Cancer Type: _____ | | <input type="checkbox"/> Genetic predisposition to cancer |
| <input type="checkbox"/> Other medical conditions: _____ | | |

Medications I do not take any medications or supplements.

Current Medication/Supplements	Dose	Current Medication/Supplements	Dose

Drug Allergies I do not have any drug allergies

Drug Allergy	Reaction

Do you have an allergy to iodine or shellfish? No Yes, reaction: _____

Please list any environmental or food allergies:

NEW PATIENT QUESTIONNAIRE

Surgical History Please list ALL prior surgeries.

I have had no prior surgeries.

Date	Surgery	Comments

Family History

No family medical history

History unknown/adopted

	Diabetes	Heart Attack	Stroke	Incontinence	Prolapse	Cancer – please list
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daughter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Son	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History

Marital Status Single Married Divorced Widowed Separated

Tobacco Use Never Current: packs/day _____, start date _____

Former smoker Start date _____ Quit date _____

Packs per day _____

Vape Use Never Current: times/day _____

Former vape use Start date _____ Quit date _____

Times per day _____

Alcohol Use No Yes, _____ # beverages per week