

UROGYNECOLOGY PATIENT QUESTIONNAIRE

Date of Appointment: ___/___/___

Date of Birth: _____

Patient Name _____

Which physician are you seeing today: Dr. Carley Dr. Boreham Dr. Roshanravan Dr. Kinman

Referring healthcare provider name/address:

Do you have a gynecologist who you have seen in the last 5 years? _____

Gynecologist name and number: _____

Primary care physician name and number: _____

Pharmacy phone number: _____

If you were referred by a healthcare provider, may we send correspondence regarding your visit and care?

Yes No

What bothers you most about your bladder or pelvic organs? (Please describe in your own words)

How long have you had this? _____

The problem is getting (*Please circle one*): **worse better no change**

Please list any other concerns regarding your bladder or pelvic organs you wish to discuss during your visit

1. Do you lose urine with any of the following activities: (Circle any that apply)

- | | | |
|-------------------------|--------------------------------|-----------------------|
| a. Coughing | b. Walking | c. Lifting |
| d. Exercise | e. Sneezing | f. Laughing |
| g. Clearing your throat | h. Running | i. Standing up |
| j. Orgasm | k. Pressure during intercourse | l. Washing your hands |
| m. Seeing water | n. Putting the key in the door | o. Showering |
| p. Cold weather | q. Other _____ | r. Other _____ |

2. From the list above, during what 3 situations does your urine loss most bother you?

3. How much does your urine loss bother you?

(*Please circle one*) **not-at-all slightly moderately greatly**

4. Do you ever lose urine while lying down?**Yes No**

5. Do you ever have a sudden urge to void and lose urine before you reach the toilet?**Yes No**

If so, how much does this bother you?

(*Please circle one*) **not-at-all slightly moderately greatly**

6. Circle the following word to best describe your urgency feeling when your bladder is full.

(*Please circle one*) **none mild moderate severe**

7. Do you ever leak urine suddenly without an urge while sitting quietly?**Yes No**

8. Do you experience complete bladder emptying for no apparent reason? **Yes** **No**
9. Are you aware of the urine loss? **Yes** **No**
10. Did you have bedwetting problems beyond age 5? **Yes** **No**
11. Do you wake up wet at night? **Yes** **No**
12. Have you wet the bed in the past year? **Yes** **No**
13. Did your urine problem start after childbirth? **Yes** **No**
14. Did your urine problem start after an operation? **Yes** **No**
15. Did your urine problem start after X-ray treatment? **Yes** **No**
16. Do you dribble urine when you stand up or cough after voiding..... **Yes** **No**
17. Do fits of laughter cause complete emptying of your bladder?..... **Yes** **No**
18. Do you lose urine in drops? **Yes** **No**
19. Do you lose urine in large amounts? **Yes** **No**
20. Do you lose urine in spurts? **Yes** **No**
21. Do you lose urine as a constant stream? **Yes** **No**
22. How many times do you leak urine per day? _____
23. If not daily, how many times do you leak urine per week? _____
24. Do you use a protective pad? **Yes** **No**
 If so, how many per day _____ per night _____
25. Have you modified any of the following activities because of urine loss: (*Circle any that apply*)
 Travel
 Social activities
 Physical recreation (exercise, walking, sports)
 Other _____
26. Do you feel it is bad enough to consider surgery? **Yes** **No**
27. Do you have a strong desire to void often? **Yes** **No**
28. Do you void often for fear of leaking? **Yes** **No**
29. Do you void often because of bladder pain or fear of pain? **Yes** **No**
30. Do you have pain during voiding? **Yes** **No**
 If so when does it occur? (*Circle all that apply*)
- | Only at the end of voiding | Only when an infection is found | After voiding | | |
|--|--|----------------------|------------|-----------|
| 31. Do you have pain as your bladder fills and decreased pain after voiding? | | | Yes | No |
| 32. How many times do you void (urinate) during the day? _____ | | | | |
| 33. How many times do you awaken from sleep to void? _____ | | | | |
| 34. Does it take you a long time to start voiding? | | | Yes | No |
| 35. Do you assume different positions to help empty your bladder? | | | Yes | No |
| 36. Do you strain to empty your bladder? | | | Yes | No |
| 37. Do you put pressure on the lower abdomen to start urination? | | | Yes | No |
| 38. Is your stream weak or prolonged? | | | Yes | No |
| 39. Do you have a sensation of incomplete emptying after voiding? | | | Yes | No |
| 40. Does the stream start and stop during urination? | | | Yes | No |
| 41. Do you feel vaginal or pelvic pressure? | | | Yes | No |
| 42. Do you see or feel something protruding from the vagina? | | | Yes | No |
| 43. Have you used a pessary (device to hold up pelvic organs) in the past? | | | Yes | No |
| 44. Do you press around the anus or in the vagina during bowel movements? | | | Yes | No |
| 45. Do you have fecal staining on your underwear? | | | Yes | No |
| 46. Do you lose control of intestinal gas (flatus)? | | | Yes | No |

47. Do you lose control of liquid stools? **Yes** **No**
48. Do you lose control of formed stools? **Yes** **No**
49. Do you have problems with constipation? **Yes** **No**
50. Do you have any blood in your stool? **Yes** **No**
51. Have you been treated for 3 or more bladder or kidney infections in your life? **Yes** **No**
52. Have you been treated for a bladder or kidney infection within the past year? **Yes** **No**
 If yes, how many infections have you had within the past year? _____
 When was the last one? _____
53. Do they occur one or 2 days after intercourse? **Yes** **No**
54. Have the infections been diagnosed by urine cultures? **Yes** **No**
55. Is your urine ever bloody? **Yes** **No**
 If so, is it painful when you notice the bleeding? _____
56. Have you ever passed gravel, sand, or stones in your urine? **Yes** **No**
57. Have you ever been treated for kidney or bladder tumors? **Yes** **No**
58. Are you sexually active? **Yes** **No**
 If so, how often do you have intercourse? _____
59. Do you have any discomfort with intercourse? **Yes** **No**
60. Do you have any vaginal dryness with intercourse? **Yes** **No**
61. Are you or your partner having sexual difficulties or concerns?..... **Yes** **No**
62. Would you like treatment for any sexual concerns?..... **Yes** **No**
63. Do you smoke? **Never** **No** **Yes** If yes how many packs per day? _____
64. How many 8 oz. glasses of water do you drink a day? _____
65. How many 8 oz. glasses of other fluids do you drink a day? _____
 What types of fluids other than water do you normally drink in a day?
 Coffee ___oz., Tea ___oz., Soda ___oz., Alcoholic Beverages ___oz, Fruit juices ___oz
66. Have you had any prior treatment for urinary leakage? **Yes** **No**
67. Have you had an operation for urinary leakage? **Yes** **No**
68. Have you ever taken medication for urinary leakage? **Yes** **No**
69. Please list any other treatments you have had for urinary leakage _____
70. Do you have mitral valve prolapse? **Yes** **No**
71. Do you have an artificial heart valve? **Yes** **No**
72. Do you have a joint (hip, knee, etc.) replacement? **Yes** **No**
73. Do you ever use antibiotics before any procedure for any reason? **Yes** **No**
 If yes, please list the reason(s) _____
74. Do you have any of the following medical conditions: (*circle any that apply*)
- | | | |
|------------------------------|--------------------------|-----------------------|
| a. Diabetes Mellitus | b. Thyroid disease | c. Pernicious anemia |
| d. Paralysis | e. Stroke | f. Multiple Sclerosis |
| g. Parkinson's Disease | h. Back or Brain surgery | i. Fibromyalgia |
| j. Blood clots in legs/lungs | k. Chronic cough | l. Smoking |
| m. Pacemaker | n. Heart failure | o. Weight problems |
| p. Glaucoma | q. Other _____ | r. Other _____ |
75. List any medications that you are currently taking (please include any vitamins or non-prescription medications).
- _____
- _____
- _____

76. Please list all allergies and the reaction you have to them:

<i>Allergies</i>	<i>Reaction Experienced</i>

77. Please list any additional medical conditions for which you have received medical treatment in the past.

78. Have you had any of the following operations/procedures? (If yes, please include the year and reason for each procedure)

Surgery/Procedure	Year	Reason for the surgery/procedure
Removal of the uterus		
Removal of the ovaries		
Bladder surgery		
Brain/Back surgery		
Cystoscopy		
Urodynamic study		
Urethral dilation		
Other		

79. If you have had your uterus removed was it performed through the abdomen or vagina? _____

80. If you have had bladder surgery was it performed through the abdomen or vagina? _____

81. How many pregnancies have you had? _____

82. How many vaginal deliveries have you had? _____

83. How many Cesarean deliveries have you had? _____

84. Were forceps used for any of your deliveries? _____

85. Did you have an episiotomy for any of your deliveries? _____

86. What was the birth weight of your largest baby? _____

87. When was your last childbirth? _____

88. What is the date of your last menstrual period? _____

89. What type of contraception are you using? _____

90. What is the date of your last Pap smear? _____

91. What is the date of your last mammogram? _____

92. Are you menopausal?..... **Yes** **No**

 If so, have you ever taken hormones?..... **Yes** **No**

 Are you currently taking hormones?..... **Yes** **No**

93. If you had previously taken hormones, but are not now, when did you stop taking them? _____

94. If you had previously taken hormones, but are not now, why did you stop taking them?

95. Do any family members have a history of urine loss? **Yes** **No**

 If so, what relationship? _____

96. Do any family members have a problem with vaginal prolapse or protrusion? **Yes** **No**

 If so, what relationship? _____

ADDITIONAL REVIEW OF SYSTEMS: If you are currently having any problems in the following areas, please circle and explain.

SKIN: Itching, rash, infection, ulcer, tumors (growths), other None

LYMPH NODES: Swelling, tenderness, other None

ENDOCRINE: Fatigue, confusion, fainting, nervousness, hot/cold intolerance, hair loss
other None

BREASTS: Tenderness, swelling lumps, discharge, other None

RESPIRATORY: Wheezing, cough (productive, blood), difficulty breathing, asthma, other None

CARDIOVASCULAR: Chest pain, swelling of extremities, shortness of breath, exercise
intolerance, other None

NERVOUS SYSTEM: Loss of sensation in arms/legs, numbness or tingling, loss of
consciousness, falls, difficulty walking, other None

BLOOD/LYMPH: Excessive bleeding, easy bruising, anemia, enlarged lymph nodes, other None

ALLERGIES/IMMUNOLOGY: Latex allergy, hay fever, other None

PSYCHOLOGICAL: Poor memory, difficulty concentration, anxiety, other None

Do you have a FAMILY HISTORY of the following? If so, whom?

	Father's Family	Mother's Family	Siblings, Children, Nieces, Nephews
Breast Cancer:			
Colon Cancer:			
Ovarian Cancer:			

Have any men in your family developed heart disease before age 55? Y / N

Have any women in your family developed heart disease before age 65? Y / N

Thank you for taking the time to complete this questionnaire.