

Brigham Urogynecology Group

@ Boston, NWH, S. Weymouth FXB

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Please complete this form in as much detail as possible before your visit.

Name _____ Age _____ Today's date _____

Who is your gynecologist? _____ Who is your PCP? _____

Please write in your own words the principle reason for this visit _____

How long have you had this problem? _____

Obstetrical and Gynecological History:

Age when your periods first started _____ Last Menstrual Period _____

Age at menopause (if applicable) _____ Birth control method (if any) _____

Have your periods been regular? Yes No If no, please describe _____

History of sexually transmitted disease? Yes No If yes, please specify _____

Number of pregnancies _____ Number of vaginal deliveries _____ or C-sections _____

Weight of largest baby _____ Forceps or vacuum deliveries? Yes No

Medical History: (check all that apply)

- Arthritis
- Asthma
- Blood clots in legs
- Diabetes
- Disc Diseases
- Glaucoma
- Heart disease
- High blood pressure
- Multiple Sclerosis
- Parkinson's
- Psychiatric disorder
- Stroke

Surgical History:

- Bladder surgery Yes No
- Hernia surgery Yes No
- Hysterectomy Yes No
- Prolapse surgery Yes No

List any other medical conditions:

List ALL previous surgeries:

Medications: (use separate sheet if necessary)

	Name	Dose/Size	How Taken
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____

Allergies: (check all that apply)

- No Known Drug Allergies
- Iodine or betadine
- Penicillin Sulfa
- Latex
- Local anesthetics
- Others _____

Brigham Urogynecology Group

Social History:	<input type="radio"/> Single <input type="radio"/> Partner <input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Widow	
Currently working	<input type="radio"/> Yes <input type="radio"/> No	If yes, type of work: _____
Regular exercise	<input type="radio"/> Yes <input type="radio"/> No	If yes, how often: _____
Sexually active	<input type="radio"/> Yes <input type="radio"/> No	If yes, any problems with intercourse: _____
Current smoker	<input type="radio"/> Yes <input type="radio"/> No	If yes, # packs/day: _____ # of years: _____
Past smoker	<input type="radio"/> Yes <input type="radio"/> No	If yes when? _____
Alcohol	<input type="radio"/> Yes <input type="radio"/> No	If yes, type: _____ how often: _____
Caffeine	<input type="radio"/> Yes <input type="radio"/> No	If yes, type(s): _____ how often: _____
Recreational drugs	<input type="radio"/> Yes <input type="radio"/> No	If yes, type: _____ how often: _____

Family History: Have any of your immediate relatives (parents, children, and siblings) had the following?		
	relationship	
Bladder Surgery	<input type="radio"/> Yes <input type="radio"/> No _____	Prolapse Surgery
Gyn Cancer	<input type="radio"/> Yes <input type="radio"/> No _____ (If yes, what type? _____)	<input type="radio"/> Yes <input type="radio"/> No _____ relationship

Have you had any new onset of the following conditions within the past 6 months?

<u>General</u>	Yes	No	<u>Gastrointestinal</u>	Yes	No
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
<u>Chest</u>	Yes	No	<u>Endocrine</u>	Yes	No
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Water Intake	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
<u>Cardiac</u>	Yes	No	<u>Neurologic</u>	Yes	No
Heart Fluttering	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss	<input type="checkbox"/>	<input type="checkbox"/>
<u>Genitourinary</u>	Yes	No	<u>Blood/Lymph System</u>	Yes	No
Burning with Urination	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	Clotting Problems	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>
<u>Skin</u>	Yes	No	<u>Psychiatric</u>	Yes	No
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Change in Mole	<input type="checkbox"/>	<input type="checkbox"/>	Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>

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URINARY INCONTINENCE (also known as leakage of urine or loss of urine)

Have you ever lost urine, even a small amount, at least once a month?

- No Yes

If you have never had any urinary incontinence, go to the next (last) page

Please describe the nature of your urine loss (check **all** that apply)

- Urine loss with "stress" (sneezing, coughing, lifting, exercising, etc.)
 Urine loss when I get the urge to urinate
 Urine loss without being aware of it
 Urine loss with sexual intercourse
 Urine loss continuously
 Urine loss with change in position (getting up, sitting down)
 Other (please explain) _____

When did you first have urine loss at least once a month?

- Less than 6 months ago 5-10 years ago
 6-23 months ago More than 10 years ago
 2-4 years ago

In the past 6 months how often did you lose urine?

- Once a month or less Once a week
 A few times a month Every day
 A few times a week

When you lose urine, how much do you leak?

- Drops (pants are damp)
 Small amounts (pants are wet)
 Large (soaked)

What do you use for protection when you leak?

- Nothing Heavy pads
 Light or thin (panty-liner) Diapers/Incontinence briefs
 Regular pads

If you use protection, how many pads do you use each day?

- None 3-6 a day
 1-2 a day Over 6 a day

Do you lose urine while you sleep (also known as "bedwetting")?

- No Yes

Do you lose urine after you have finished emptying your bladder?

- No Yes

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The following questions have to do with your bladder symptoms

Urgency is defined as a sudden compelling desire to pass urine which is difficult to defer.

It is a strong need to urinate that cannot be delayed.

- Do you have urgency? No Yes
- How often do you urinate during the day from the time you wake up until you go to sleep? _____
- Do you wake up from sleep to urinate? No Yes
If yes, specify on average how many times you wake up to urinate _____
- Do you have trouble starting your urine flow? No Yes
- Do you have to strain to urinate? No Yes
- After urinating, do you...
 - Have a sensation of still having urine in your bladder? No Yes
 - Have dribbling of urine when you stand up? No Yes
- Do you have any discomfort or pain with urination? No Yes
- Do you have blood in your urine? No Yes
- Have you ever had a urinary tract infection? No Yes
If yes, how many in the past year? _____ Did you receive antibiotics? _____
- Have you ever had a kidney infection? No Yes
- Have you ever had a bladder or kidney tumor? No Yes
- Have you ever had treatment for bladder injury? No Yes
- Did you have trouble holding urine as a child? No Yes
- Have you had dilation (stretching) of the urethra? No Yes
If yes, when did you have this? _____ and how many times? _____

The following questions have to do with your bowel habits

- How often do you have a bowel movement? _____ times per day or week
- Do you have frequent constipation? No Yes
- Do you have frequent diarrhea (loose/watery stools)? No Yes
- Do you usually run to the toilet with a bowel movement? No Yes
If, yes, can you make it on time? _____
- Do you have discomfort/pain with a bowel movement? No Yes
- Do you have accidental (involuntary) leakage of gas? No Yes
- Do you have accidental leakage of stools? No Yes
If yes, do you leak liquid or solid stool?
If yes, when did it start? _____ and how often does it happen? _____

The following questions have to do with prolapse (dropped female organs)

- Do you have a lump in vagina? No Yes
- Do you have to push the bulge in to urinate? No Yes
- Do you push the bulge in to have a bowel movement? No Yes
- Do you have low back pain? No Yes
- Do you have pelvic pain or pressure? No Yes

Completed by: (Print Patient's Name) _____ Signature: _____ Date _____
Forms Reviewed by physician _____ Date _____