Brigham Urogynecology Group

@ ____Boston, ____ NWH, ____Braintree ____ 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_____
_____
_____

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

Family History: *Have any of your immediate relatives (parents, children, and siblings) had the following?*

			relationship				relationship
Bladder Surgery	❑ Yes	❑ No	_____	Prolapse Surgery	❑ Yes	❑ No	_____
Gyn Cancer	❑ Yes	❑ No	_____ (If yes, what type?_____)				

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

General	**Yes**	**No**	**Gastrointestinal**	**Yes**	**No**
Fever	□	□	Nausea/vomiting	□	□
Chills	□	□	Blood in stools	□	□
Weight Loss	□	□	Diarrhea	□	□
Weight Gain	□	□	Constipation	□	□

Chest	**Yes**	**No**	**Endocrine**	**Yes**	**No**
Cough	□	□	Hot Flashes	□	□
Shortness of breath	□	□	Night Sweats	□	□
Wheezing	□	□	Excessive Water Intake	□	□
Asthma	□	□	Excessive Fatigue	□	□

Cardiac	**Yes**	**No**	**Neurologic**	**Yes**	**No**
Heart Fluttering	□	□	Headaches	□	□
Chest Pain	□	□	Blurred Vision	□	□
Dizziness	□	□	Numbness	□	□
Tingling	□	□	Memory loss	□	□

Genitourinary	**Yes**	**No**	**Blood/Lymph System**	**Yes**	**No**
Burning with Urination	□	□	Swollen Glands	□	□
Blood in Urine	□	□	Bleeding Problems	□	□
Recurrent Bladder Infections	□	□	Clotting Problems	□	□
Vaginal Discharge	□	□	Bleeding gums	□	□

Skin	**Yes**	**No**	**Psychiatric**	**Yes**	**No**
Bruise Easily	□	□	Depression	□	□
Rash	□	□	Anxiety	□	□
Change in Mole	□	□	Mood Swings	□	□
Itching	□	□	Difficulty Sleeping	□	□

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

In the past 6 months how often did you lose urine?
□ Once a month or less
□ A few times a month
□ A few times a week
□ Once a week
□ Every day

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
□ Light or thin (panty-liner)
□ Regular pads
□ Heavy pads
□ Diapers/Incontinence briefs

If you use protection, how many pads do you use each day?
□ None
□ 1-2 a day
□ 3-6 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_____