Urogynecology New Patient Intake Form

Name _____ Date of Birth _____ Age _____

Referring Provider _____

What is the main reason for your visit?

_____

_____

_____

Have you received any treatments for this issue in the past?

_____

_____

_____

What are your goals for the visit today?

1. _____

_____

2. _____

_____

3. _____

_____

Urinary Symptoms:

Do you experience urinary leakage? Yes/No

If yes, how long? _____ months/years

Please check if you leak urine during the following times:

☐ coughing/sneezing/laughing ☐ walking/running/exercising ☐ with intercourse

☐ with urgency/on the way to the bathroom ☐ minimal activity ☐ lying down

Do you use a pad for leakage? Yes/No

If yes, how many in a day? _____

What amount of leakage do you experience? ☐ Drops ☐ More than drops ☐ Flood

How long can you postpone emptying your bladder when you have the urge? _____min/hr

After emptying your bladder do you feel like you have completely finished? Yes/No

Do you find it hard to begin urinating? Yes/No

How many times do you urinate during the day? _____

How many times do you urinate during the night after you go to sleep? _____

Number of urinary tract infection in the last year? _____

Any kidney infections (pyelonephritis)? Yes/No

Any history of kidney stones? Yes/No

Any blood in the urine? Yes/No

Did you have any urinary problems in childhood? Yes/No

Bowel Symptoms:

How often do you have a bowel movement? _____

Do you strain to have a bowel movement? Yes/No

Do you push with a finger in the vagina to assist with a bowel movement? Yes/No

Do you have constipation? Yes/No

Do you use any laxatives? Yes/No

Do you have diarrhea/loose stools?

Do you have fecal urgency and do not make it to the bathroom in time? Yes/No

Do you have fecal seepage or staining on your underwear? Yes/No

Do you usually lose stool beyond your control if your stool is loose? Yes/No

Do you have difficulty controlling formed stool? Yes/No

Prolapse Symptoms:

Do you feel any vaginal or lower abdominal pressure? Yes/No

Do you see or feel a bulge or something falling out in the vaginal area? Yes/No

Do you see or feel a bulge or something falling out in the rectal area? Yes/No

Sexual Symptoms:

Have you *ever* had sexual relations? Yes/No

If yes, do you have pain with sex? Yes/No

If yes, are you satisfied with your sex life? Yes/No

Are you *currently* having sexual relations? Yes/No

Do you have any major medical problems (i.e. diabetes, high blood pressure)? _____

_____

Have you ever had problems with heart problems, blood clots, or anesthesia problems? Yes/No

Explain:_____

What surgeries have you had in the past? _____

_____

What medical problems run in your family? _____

_____

What medication do you take (include over the counter medications, herbal medications, and vitamins)?_____

_____

What allergies do you currently have (medications, latex, foods, environment)?_____

_____

Patient Label
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How many times have you ever been pregnant?_____

Of these pregnancies, how many were: preterm (premature) deliveries _____
full term deliveries _____
miscarriages or abortions _____

Of the deliveries, how many were: vaginal deliveries only? _____
vaginal deliveries with forceps assistance? _____
vaginal deliveries with vacuum assistance? _____
cesarean deliveries? _____

Of the vaginal deliveries, did you have any large tears (3rd or 4th degree)? Yes/No

What is the weight of your largest baby? _____

When was the first day or your last period? _____

How often do you have your period? _____

How long does your period last? _____

Have you ever had an abnormal pap test? _____

Have you ever had a pelvic infection (i.e. gonorrhea, chlamydia, herpes)? _____

Do you have a sexual partner? _____ Is that partner male or female? _____

When was your last:

Pap test	_____	Colonoscopy	_____
Mammogram	_____	Bone Density test	_____
Cholesterol screen	_____	Tetanus shot	_____

Are you? Single/Married/Partnered/Divorced/Widowed

Who do you live with? _____

Are you currently? Working/Retired/Unemployed

What is your occupation?_____

Do you exercise regularly? Yes/No

Describe your current exercise routine: _____

We recommend limiting tobacco use. Do you currently smoke? Yes/No

If yes, how many cigarettes or packs per day? _____

If yes, would you like help quitting smoking? Yes/No

Have you ever smoked in the past? Yes/No

If yes, when did you quit? _____

How much alcohol do you use: _____day/week/month

What street drugs do you use? _____ How often? _____

Domestic violence (including emotional physical and sexual abuse) is a serious health threat to women. Has anyone hurt you in the past? _____

Is anyone hurting you now in any way? _____

Update of Personal Medical History and Review of Symptoms

If you have a problem now, or if you have had a problem with any of the following body systems in the past, please check and explain at the bottom. Thank you.

Cardiovascular

_____ Blood pressure
_____ Heart
- _____ Heat attack
- _____ Chest pain-angina
- _____ Murmur-valve problem
- _____ Failure

_____ Blood vessels

Respiratory

_____ Lungs (Breathing problems, Asthma, TB)
_____ Cough
_____ Wheezing
_____ Shortness of breath

Gastroenterological

_____ Abdomen (constipation, ulcers)
_____ Rectum
_____ Liver (hepatitis)

Endocrine

_____ Diabetes
_____ Thyroid

Eyes, Ear, Nose, Throat

_____ Eyes
_____ Ears
_____ Nose and Sinuses
_____ Mouth
_____ Throat

Genitourinary

_____ Breast
_____ Uterus
_____ Ovaries
_____ Kidney
_____ Pelvis Infection
_____ Vagina
_____ Tubes
_____ Cervix
_____ Incontinence

Musculoskeletal

_____ Joints (arthritis)
_____ Muscles
_____ Bones

Dermatologic

_____ Skin/rashes, moles, ulcers
_____ Lymph nodes

Neurological

_____ Loss of sensation
_____ Loss of strength
_____ Memory loss
_____ Dizziness / fainting
_____ Migraines
_____ Seizures

Hematologic

_____ Anemia
_____ Blood clots
_____ Easy Bleeding
_____ HIV
_____ Blood transfusion

Psychiatric

_____ Schizophrenia
_____ Depression
_____ Anxiety
_____ Insomnia

Notes: _____

_____

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Wake Specialty Physicians
Women's Center
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