LVPG UROGYNECOLOGY

New Patient History

MRN _____ Name_____ Today's Date_____

Complaint: _____

Referring Physician: _____ Primary Care Physician: _____

Gynecologist: _____ Do you currently see other specialists? _____

If yes, list the doctor and specialty: _____

Obstretrical and Gynecological History	**Surgical History**
Age of onset of first period: _____ Date of last menstrual period: _____ Periods: Regular ____ Irregular _____ Heavy or painful periods: Yes ___ No ____ Sexually active: Yes ___ No ____ Bleeding with intercourse: Yes ___ No ___ Pain with intercourse: Yes ___ No ___ Age at menopause: _____ Postmenopausal bleeding: Yes ___ No ___ Year of last pap smear: _____ History of abnormal pap: Yes ___ No ___ History of hormone therapy: Oral ____ Patch ____ Vaginal _____ History of: Ovarian cysts ____ Fibroids ____ Sexually transmitted diseases ____ # of pregnancies: ____ # of live births: ____ # of miscarriages: ____ # of abortions: ____ Largest birth weight: ____ History of: **Circle all that apply**: forceps / vacuum assisted deliver / episiotomy / perineal laceration / birth related pelvic injury	Any history of pelvic surgery: Month/Year: _____ Procedure: _____ Any history of (Circle all that apply) urethral / bladder / gynecologic surgery / bowel Month/Year: _____ Procedure: _____ History of hysterectomy: Yes ___ No ___ If yes: Total ___ Partial ___ (Ovaries and tubes conserved) Month/Year: _____ Route: (circle) vaginal / laparoscopic / open abdominal / robotic History of tubal ligation: Yes ___ No ___ History of urologic surgery: (Circle) kidney / ureter / bladder / urethra Month/Year: _____ Procedure: _____ Incontinence surgery: Yes ___ No ___ Month/Year: _____ Procedure: _____ Other surgery: Month/Year: _____ Procedure: _____ Other surgery: Month/Year: _____ Procedure: _____

Bladder Habits	
# of voids per day: ____ # of times you wake up at night to void: ____ # of episodes of urgency per day: ____ # of leaks with urgency per day: ____ # of leaks with laugh, cough or sneeze per day: ____ # of leaks with exercise, lifting, bending over: ____ Which is more bothersome, leakage with activities or with urge? Or are they equally bothersome? _____ Perform kegal exercises: Yes ___ No ___ Prior pelvic floor rehab or biofeedback: Any prior overactive bladder or bladder control medications: **Circle all the apply**: Detrol LA/Ditropan XL / Oxybutynin / Oxytrol Patch/ Sanctura (Trospium) / Imipramine / Enablex / Myrberiq / Vesicare / Flomax / Estrogen cream Any help? Yes ___ No ___ Which ones? _____ Side effects? Yes ___ No ___ Which ones? _____	# of pads used to stay dry per day: _____ # of leaks without activity or sensation: ____ Leakage with intercourse: Yes ___ No ___ Bedwetting: Yes ___ No ___ # of sugar substitutes used per day: _____ # of caffeinated drinks per day: _____ # of carbonated drinks per day: _____ Hesitancy to start urinating: Yes ___ No ___ Straining to maintain flow: Yes ___ No ___ Dribbling after urinating: Yes ___ No ___ Incomplete bladder emptying: Yes ___ No ___ Urine stream: (**Circle what applies**) slow/interrupted/strong

Bowel Habits	
How often do you move your bowels? **Circle all that apply:** Daily / every other day / ___ per week Bowel consistency: **(Circle)** formed / hard / soft / loose / liquid History of constipation: Yes ___ No ___ Excessive straining with bowel movement: Yes ___ No ___ Incomplete bowel emptying: Yes ___ No ___ Do you use: **Circle all that apply:** supplemental fiber / stool softeners / laxative Prior use of: Imodium ____ lomotil ____	Year of last colonoscopy (if applicable): _____ Findings: _____ Fecal incontinence: Yes ___ No ___ **If yes, circle all that apply:** loose / liquid / solid stool / flatus # of episodes per week: ____ Prior treatment for incontinence: **Circle all that apply:** Surgery / fiber / lomotil / Imodium / biofeedback / pelvic floor rehab

Bladder/Pelvis Assessment	
Lower Urinary Tract Symptoms: **Circle all that apply:** Gross Hematuria(Blood in Urine) / dysuria/ burning with urination / pain with full bladder / urinary odor / cloudy urine Last Urinary Tract Infection (UTI): _____ # of UTI's in last 6 months: ____ In the last year: ____ Prior antibiotics used: _____ Long term antibiotic used: Yes ___ No ___ Pelvic pain: Yes ___ No ___ Location: _____ **Circle all that apply**: Sharp / stabbing / throbbing / crampy What makes pain worse: _____ What makes pain better: _____ Frequency: Constant ___ Intermittent ___ Prior treatments: **Circle all that apply**: Elavil / Elmiron / pudendal blocks / bladder instillation / Neurotin / narcotics / NSAIDs / physical therapy / pyridium / Uribel / cystoscopy / hydrodistension / vaginal valium / muscle relaxant	Pelvic Organ Prolapse: **Circle all that apply:** pelvic pressure / heaviness sensation / dullness sensation / vaginal bulge / splinting / support to vagina, rectum, or perineum to complete a bowel movement or urination Prior pessary treatment: Yes ___ No ___ If yes, type of pessary: _____ Prolapse surgery: Yes ___ No ___ Sexual dysfunction: (If sexually active) Pain with intercourse: Yes ___ No ___ Pain on entry ___ deep pain ___ Urinary incontinence with intercourse: Yes ___ No___ Bowel incontinence with intercourse: Yes ___ No ___ Avoidance of sexual relations due to: **Circle all that apply:** pain / prolapse / incontinence of urine or bowel / vaginal dryness Lack of interest in sexual intimacy: Yes ___ No ___ If yes, why: _____