

UROGYNECOLOGY OF SOUTHERN ALABAMA

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INITIAL CONSULTATION

Last Name _____ First Name _____ Age _____

Date of Birth _____ Date of Appointment _____ Race _____

Referring Physician _____

CHIEF COMPLAINT (Why do you want to see the doctor today?)

GYN HISTORY

Number of pregnancies? ____ Vaginal births? ____ C-sections? ____

Weight largest baby? ____

Complications of childbirth? _____

Date of last period _____ Birth control method (if applicable) _____

Do you use hormone replacement? ____ What type? _____

Date of last Pap smear ____ Have you been treated for abnormal Pap smears? _____

If "yes", how? _____ Date of last mammogram _____

URINARY INCONTINENCE

Do you have problems with urinary urgency, frequency or accidental loss of urine? _____

IF YOU ANSWERED "YES", CONTINUE IF "NO", SKIP TO THE NEXT SECTION

How many months or years have you had leakage of urine? _____

How many trips do you make to the bathroom in a day? _____

How many times do you wake up at night to go to the bathroom? _____

Do you use pads to absorb lost urine? - - Y N How many? _____

If you leak urine, would you describe it as

Frequent small amounts - - - Y N

Continuous loss (always wet) - - - Y N

Infrequent but large loss of urine - - Y N

Do you ever wet the bed while sleeping? - - Y N

Are you bothered by a strong sense of urgency to void? Y N

Do you sometimes not make it to the bathroom in time? Y N

Does the sound/feel of running water cause you to leak? Y N

Do you lose urine without any warning? - - Y N

If you are sexually active, do you lose urine

During intercourse - - - Y N

With deep penetration - - - Y N

During orgasm - - - Y N

URINARY INCONTINENCE (con't)

Which best describes urine loss with activity? I lose urine

When I go home before I can put my key in the door Y N

When I cough, sneeze or lift a heavy object - Y N

Continuously so that I am constantly wet - Y N

Have you seen a physician for complaints of urine loss? Y N

Have you taken medications to prevent urine loss? - Y N

(If yes, circle) Detrol Ditropan Sanctura Vesicare Enablex Oxytrol

Have you had surgery to prevent urine loss? - - Y N

If yes, name of operation _____ Date _____

If yes, did the surgery help? - - - Y N

VOIDING DYSFUNCTION

Do you have difficulty urinating or emptying your bladder? Y N

IF "YES", CONTINUE, IF "NO", SKIP TO NEXT SECTION

Do you dribble more urine when you stand up after urinating? Y N

Do you have difficulty starting your urine stream? - Y N

Do you have to assume an abnormal position to urinate? - Y N

Do you strain to empty your bladder? - - - Y N

Do you feel that your bladder does not empty when you urinate? Y N

Is your urine flow (circle one) Strong Weak Dribbling Start-stop

PROLAPSE

Do you feel pressure or fullness in your vagina? Is there a bulge/protrusion through the opening?

IF "YES", CONTINUE, IF "NO", SKIP TO NEXT SECTION

How long have you had this bulge or mass? _____

Is this more noticeable at the end of the day or after standing? Y N

Do you ever push the bulge back to empty your bladder or bowels? Y N

Have you seen a doctor for this? - - - - Y N

Have you used a pessary for this? - - - - Y N

Have you ever had surgery for a vaginal bulge (prolapse)? - Y N

If yes, what was the operation? _____ Date _____

BOWEL DYSFUNCTION

Do you have problems with your bowels? - - Y N

IF "YES", CONTINUE, IF "NO", SKIP TO NEXT SECTION

Do you have accidental loss of Solid stool? - - Y N

Liquid stool? - - Y N

Gas? - - - Y N

How long have you had this problem? _____

How many times per week do you experience this? _____

Do you wear protective pads for this? - - - Y N #/day? _____

Have you seen a doctor for this problem? - - Y N

Have you had surgery for this? - - - Y N When? _____

