UROGYNECOLOGY QUESTIONNAIRE

Date of Review: _____

NAME _____ I.D. _____/_____
LAST FIRST MIDDLE Family Prefix/ Sponsor's SSN

REFERRING PROVIDER _____ DOB _____/_____/_____
MONTH DATE YEAR

PHARMACY PREFERRED _____ AGE _____

GENERAL INFORMATION

Nature of Problem: _____
_____

Which symptom is the most bothersome? _____
How long have you had these symptoms? _____

SYMPTOMS

UROLOGIC

General

1. How often do you typically urinate during the day? Every _____ hours or _____ (number of) times per day

2. How often do you urinate during the night after you've gone to bed _____ (number of times) per night

Diet/Fluid intake

3. Do you drink coffee, tea, or caffeinated soda? If so, please estimate how much. _____

Incontinence

4. Do you ever leak urine? ☐ No ☐ Yes

   If yes, how often? ☐ Less than once a month
   ☐ One to several times a month
   ☐ One to several times a week
   ☐ Every day and/or night

   How much urine do you lose each time? ☐ Drops ☐ Small splashes ☐ More

5. Do you wear protection (pads, diapers, tissues, etc) for urinary loss? ☐ No ☐ Yes
   What type of protection do you use? ☐ Tissue ☐ Mini-pad ☐ Regular pads ☐ Diapers

Stress

6. Check if you lose urine in spurts during any of the following activities:
   Sudden increases in abdominal pressure such as:..... ☐ Exercising ☐ Sneezing ☐ Laughing
   ☐ Coughing ☐ Walking ☐ Standing up

Urge

7. When you feel the urge, do you have to rush to the bathroom? ☐ No ☐ Yes

8. Once feel the urge to urinate, do you lose urine before reaching the toilet? ☐ No ☐ Yes

Treatments

9. Have you ever tried Kegel or pelvic floor exercises to help your problems? ☐ No ☐ Yes
   If so, did they help? ☐ No ☐ Yes

10. Have you ever been given medication to help for your leakage problem? ☐ No ☐ Yes
    If so which medication? ☐ Detrol ☐ Ditropan ☐ Vesicare ☐ Enablex
    How long did you stay on this medication? Days _____ Weeks _____ Months _____

11. Have you ever had an operation to help your leakage problem? ☐ No ☐ Yes

Other Bladder problems

12. Ever had blood in your urine not associated with a bladder infection? ☐ No ☐ Yes

13. Do you have a history of urinary tract infections? ☐ No ☐ Yes
    If so, how many UTI's did you have last year? _____ (number last year)

14. Do you have difficulty emptying your bladder? ☐ No ☐ Yes
    Please check all that apply regarding difficulty emptying your bladder:
    - Delay in starting (Must bear down to start flow) ☐ No ☐ Yes
    - Straining (Must bear down to continue flow) ☐ No ☐ Yes
    - Poor or weak flow ☐ No ☐ Yes
    - Intermittent flow (Stops & starts throughout flow) ☐ No ☐ Yes
    - Incomplete voiding (Return to bathroom w/in minutes of voiding) ☐ No ☐ Yes
    - Dribbling after voiding(Weak flow continues if you remain on toilet) ☐ No ☐ Yes

15. Do you have pain when your bladder is full? ☐ No ☐ Yes
    If so, does the pain resolve when you empty your bladder? ☐ No ☐ Yes

PROLAPSE

16. Do you ever feel a bulge in the vagina or that something is falling out? ☐ No ☐ Yes

GASTROINTEROLOGY - BOWEL FUNCTION

17. How many bowel movements do you have? _____ (number)/day OR _____(number)/week

18. Do you ever have difficulty evacuating stool? ☐ No ☐ Yes

19. Do you have to push on your bottom or inside your vagina to evacuate? ☐ No ☐ Yes

20. Do you require laxatives to have a bowel movement? ☐ No ☐ Yes How often?_____

21. Do you ever leak stool or gas accidentally? ☐ No ☐ Yes
    If yes, which kind? ☐ Solid stool ☐ Liquid stool ☐ Gas
    How many episodes of this leakage do you experience? ____ x/day _____x/week _____x/month

GYNECOLOGIC

22. Are your periods regular (about every month?) ☐ No ☐ Yes ☐ N/A menopause or prior hysterectomy
    - Are they severely painful? ☐ No ☐ Yes
    - How long do they last? _____ days
    - What was the date (first day) of your last period? _____

23. Are you sexually active at this time in your life? ☐ No ☐ Yes
    If yes, how often ____ x/week _____x/month _____x/year
    If no sexual activity, is this okay with you? ☐ No ☐ Yes
    Do these activities include vaginal intercourse? ☐ No ☐ Yes

24. Do you have pain with intercourse? ☐ No ☐ Yes
    If yes, where is the pain? ☐ Superficial ☐ Deep ☐ Both

25. Do you ever leak urine with vaginal intercourse? ☐ No ☐ Yes
    If yes, when does it occur? ☐ With penetration ☐ With orgasm ☐ Both

26. Is your sex life satisfactory for you? ☐ No ☐ Yes ☐ I'm not sexually active, but I'm okay with that

27. Do you have any sexual concerns that you would like to address? ☐ No ☐ Yes

MEDICATION

28. Please list all medications (including dosages) that you are currently taking. INCLUDE any Over-the-Counter (OTC) medications as well as any Diet or Herbal Supplements:

Medication	Dosage	Medication	Dosage
1		7	
2		8	
3		9	
4		10	
5		11	
6		12	

ALLERGIES

29. Do you have any drug allergies? ☐ No ☐ Yes
If yes, please list them: _____
_____

MEDICAL HISTORY:

30. Please list medical problems with which you have been diagnosed (eg. Hypertension, diabetes, asthma, arthritis, cancer)

1		7	
2		8	
3		9	
4		10	
5		11	
6		12	

31. Please note if **any of your close family members (Father, Mother, Brother(s), Sister(s), Grandparent(s), or Children)** have had:

Heart disease/attacks	☐ No	☐ Yes	Who:_____
Stroke	☐ No	☐ Yes	Who:_____
Blood clots (PE, DVT)	☐ No	☐ Yes	Who:_____
Breast cancer	☐ No	☐ Yes	Who:_____
Colon cancer	☐ No	☐ Yes	Who:_____
Bladder cancer	☐ No	☐ Yes	Who:_____
Uterine cancer	☐ No	☐ Yes	Who:_____
Ovarian cancer	☐ No	☐ Yes	Who:_____
Other cancer:_____			Who:_____

SURGICAL HISTORY

32. Have you ever had a hysterectomy? ☐ No ☐ Yes

33. Have you had your ovaries removed? ☐ No ☐ Yes

34. Have you had any other surgeries? ☐ No ☐ Yes (please list below)

Type	Date, Year or Age
1	
2	
3	
4	
5	
6	

GYNECOLOGICAL HISTORY

35. What do you presently use for birth control? _____ ☐ N/A menopause or prior hysterectomy

36. When was your last PAP smear? _____
What were the results? ☐ Normal ☐ Abnormal
Have you ever had an abnormal PAP smear? ☐ No ☐ Yes

37. When was your last mammogram (in Radiology)? _____
What were the results? ☐ Normal ☐ Abnormal

38. Have you gone through menopause? ☐ No ☐ Yes
It occurred: ☐ Naturally ☐ Surgically
At what age? _____ years old

39. Have you ever been on Hormone Replacement Therapy (HRT)? ☐ No ☐ Yes
If yes, what medication? _____
How many years were you on HRT? _____ years

40. When was your last sigmoidoscopy or colonoscopy (circle one) _____
What were the results? ☐ Normal ☐ Abnormal

PREGNANCY HISTORY

41. TOTAL number of pregnancies (regardless of end results): _____

Pregnancy	Year	# Weeks at delivery	Method of Delivery		Surgical		Perineal Lacerations		Newborn Weight
			Vaginal	C-Section	Forceps	Vacuum	3rd degree	4th degree	
1.	_____	_____	☐	☐	☐	☐	☐	☐	_____
2.	_____	_____	☐	☐	☐	☐	☐	☐	_____
3.	_____	_____	☐	☐	☐	☐	☐	☐	_____
4.	_____	_____	☐	☐	☐	☐	☐	☐	_____
5.	_____	_____	☐	☐	☐	☐	☐	☐	_____

42. Did you ever have any urinary or bowel problems immediately following delivery? ☐ No ☐ Yes
Please describe: _____

SOCIAL HISTORY

43. Have you EVER used tobacco products (cigarettes, cigars, snuff, pipes) ☐ Never ☐ Smoked in past ☐ Currently smoke
If so, how many years have you smoked? _____ years
How many packs of cigarettes do/did you smoke a day? _____ (smallest #) to _____ (largest #) of packs

44. Do you drink alcoholic beverages? ☐ No ☐ Yes
If yes, how many drinks (2 oz liquor, 6 oz wine, 12 oz beer)? _____ /day _____/week _____/month

45. Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

46. Please indicate your military status: ☐ Active Duty ☐ Family Mem ☐ Retired ☐ Reserves

47. Number of people living in your household: _____

48. Your Occupation: _____

49. Have you ever (as a child or adult) experience physical, verbal or sexual abuse? ☐ No ☐ Yes
If yes, are you worried that any family member, friend, or acquaintance MIGHT treat you in this manner now or in the future? ☐ No ☐ Yes

50. What is the most physically active thing you do - currently? _____
How often do you perform this activity? _____ /day _____/week _____/month
How long do you perform it? _____min _____hours

PROVIDER reviewing history:

_____
Please print or stamp name