SLUCare Physician Group

MRN #: _____

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Urogynecology and Pelvic Reconstructive Surgery
Obstetrics, Gynecology and Women's Health
Medical History Questionnaire

Patient's Name: _____ Date Form Filled: _____ Date of Birth: _____

Physician Information

Name of Referring Physician: _____

Name of Primary Physician: _____

Present Condition

In your own words, describe why you have been asked to come here: _____

_____

Problems

☐ Yes ☐ No Do you leak urine with coughing, sneezing, laughing, etc.?
☐ Yes ☐ No Do you leak urine trying to get to the bathroom in time?
☐ Yes ☐ No Do you urinate too frequently?
☐ Yes ☐ No Do you wake up at night to urinate?
☐ Yes ☐ No Is it hard to empty your bladder?
☐ Yes ☐ No Is constipation a problem?
☐ Yes ☐ No Do you lose bowel movement or gas by accident?
☐ Yes ☐ No Is there pressure in your bottom or bulge of your female organs?
☐ Yes ☐ No Do you have a lot of bladder or urinary infections?

Medical Problems Please check "Yes" or "No" for each problem.

☐ Yes ☐ No Abnormal pap
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Cancer
☐ Yes ☐ No Crohn's disease/Ulcerative colitis
☐ Yes ☐ No Depression
☐ Yes ☐ No Epilepsy/seizures
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Heart murmur
☐ Yes ☐ No Heartburn/GERD
☐ Yes ☐ No HPV
☐ Yes ☐ No Intestinal cystitis
☐ Yes ☐ No Migraines
☐ Yes ☐ No Sickle cell trait
☐ Yes ☐ No Syphilis
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Anemia
☐ Yes ☐ No Asthma
☐ Yes ☐ No Cataracts
☐ Yes ☐ No Congenital heart disease
☐ Yes ☐ No DVT (blood clots)
☐ Yes ☐ No Fibromyalgia
☐ Yes ☐ No Gonorrhea
☐ Yes ☐ No Heart problems
☐ Yes ☐ No Herpes
☐ Yes ☐ No Hypertension
☐ Yes ☐ No Kidney disease
☐ Yes ☐ No Osteoporosis/ penia
☐ Yes ☐ No Sickle cell disease
☐ Yes ☐ No Thyroid disease
☐ Yes ☐ No Type 1 diabetes
☐ Yes ☐ No Anesthetic complications
☐ Yes ☐ No Bladder/kidney infections

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Medical Problems (Continued) Please check "Yes" or "No" for each problem.

☐ Yes ☐ No	Chlamydia	☐ Yes ☐ No	Irritable bowel syndrome
☐ Yes ☐ No	Congestive heart failure	☐ Yes ☐ No	Kidney stones
☐ Yes ☐ No	Emphysema/COPD	☐ Yes ☐ No	Pulmonary embolus
☐ Yes ☐ No	Gestational diabetes	☐ Yes ☐ No	Stroke
☐ Yes ☐ No	Heart attack	☐ Yes ☐ No	Trichomonas
☐ Yes ☐ No	Hepatitis: viral	☐ Yes ☐ No	Type 2 diabetes
☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No	Other (please list)

Surgical History Please check "Yes" or "No" for each problem.

☐ Yes ☐ No	Appendectomy	☐ Yes ☐ No	Single ovary removed
☐ Yes ☐ No	Cervical cerclage	☐ Yes ☐ No	Abdominal hysterectomy
☐ Yes ☐ No	C-Section	☐ Yes ☐ No	Vulvar biopsy
☐ Yes ☐ No	Hernia repair	☐ Yes ☐ No	Cervical biopsy
☐ Yes ☐ No	Mastectomy	☐ Yes ☐ No	Cervical cone biopsy
☐ Yes ☐ No	Tonsillectomy	☐ Yes ☐ No	Heart bypass surgery
☐ Yes ☐ No	Tubal ligation	☐ Yes ☐ No	LEEP
☐ Yes ☐ No	Ovaries and tubes removed	☐ Yes ☐ No	Ovarian cyst removed
☐ Yes ☐ No	Gallbladder removed	☐ Yes ☐ No	Vaginal hysterectomy
☐ Yes ☐ No	D & C	☐ Yes ☐ No	Other (list)
☐ Yes ☐ No	Hysteroscopy		

Family Medical History

What have your family members suffered from medically?

Medical Problem	**Which relative(s) had this?**
Diabetes	
Breast cancer	
Ovarian cancer	
Colon cancer	
Uterine cancer	
Osteoporosis	
Heart disease	
Hypertension	
Hyper cholesterol	
Clot in lung	
Depression	
Stroke	
Heart failure	
Thyroid disease	
Other- list	

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Social History Tell us about yourself and your habits.

Tobacco Use: ☐ I currently smoke _____ pack(s)/day for _____ years
☐ I have never smoked
☐ I used to smoke, but quit in _____
☐ I have only been exposed to passive smoke (other smoke, but not me)
☐ I use chewing tobacco

Alcohol Use: ☐ I do not drink alcohol
☐ I currently use alcohol, and drink about _____ drinks a week

Street Drug Use: ☐ Yes, I use street drugs List kinds: _____
☐ No, I don't use street drugs

Gynecological History

Are you sexually active? ☐Yes ☐ No

Do you use birth control? ☐ Yes ☐ No If yes, I use: _____

Last menstrual period: _____

Total pregnancies: _____

Number of deliveries: _____

Number of living children: _____

Weight of largest baby born vaginally: _____

Number of deliveries using forceps: _____

Number of deliveries using vacuum: _____

Torn into rectum during delivery of baby(s)? Yes No

Occupation: _____ ☐ Unemployed ☐ Retired

Last pap smear: Date: _____ ☐ Normal ☐ Abnormal

Last Mammogram: Date: _____ ☐ Normal ☐ Abnormal

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Review of Systems Please check those that have bothered you in the last few months.

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fatigue
- ☐ Malaise
- ☐ Anorexia
- ☐ Weight loss

Eyes
- ☐ Contacts/Glasses
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Visual disturbance
- ☐ Irritation
- ☐ Redness
- ☐ Yellow in Eyes

Ears, nose, mouth, throat, and face
- ☐ Hearing loss
- ☐ Ringing in the ears
- ☐ Ear drainage
- ☐ Earache
- ☐ Nasal congestion
- ☐ Bloody nose
- ☐ Snoring
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness

Respiratory
- ☐ Cough
- ☐ Sputum
- ☐ Coughing up blood
- ☐ Sharp pain with breathing
- ☐ Pneumonia
- ☐ Asthma
- ☐ Wheezing
- ☐ Shortness of breath with exertion
- ☐ Emphysema

Cardiovascular
- ☐ Chest pain
- ☐ Chest discomfort
- ☐ Shortness of breath
- ☐ Palpitations
- ☐ Irregular heart beat
- ☐ Fainting

Gastrointestinal
- ☐ Difficulty swallowing
- ☐ Painful swallowing
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Change in bowel habits
- ☐ Bloody or black bowel movement

Genitourinary
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Waking up at night to urinate
- ☐ Leaking urine
- ☐ Difficulty urinating
- ☐ Decreased stream
- ☐ Blood in urine

Integument/breast
- ☐ Rash
- ☐ Skin lesion(s)
- ☐ Dryness
- ☐ Skin color change
- ☐ Changed mole
- ☐ Breast lump
- ☐ Nipple discharge

Hematologic/lymphatic
- ☐ Easy bruising
- ☐ Easy bleeding
- ☐ Swollen glands
- ☐ Broken blood vessels on skin

Musculoskeletal
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Stiff joints
- ☐ Neck pain
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Bone pain

Neurological
- ☐ Headaches
- ☐ Dizziness
- ☐ Seizures
- ☐ Memory problems
- ☐ Speech problems
- ☐ Tingling/numbness
- ☐ Coordination problems
- ☐ Difficulty walking
- ☐ Tremor
- ☐ Weakness

Behavioral/Psych
- ☐ Anxiety
- ☐ Depression
- ☐ ADHD
- ☐ Bipolar disorder
- ☐ Alcoholism

Endocrine
- ☐ Diabetes
- ☐ Fertility problems
- ☐ Temperature intolerance

Allergic/immunologic
- ☐ Rashes
- ☐ Hay fever
- ☐ Anaphylaxis

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Voiding Diary/Urolog Instructions

The chart on the next page is a record of your voiding (urinating) and incontinence (leakage) of urine. Please complete this according to the following instructions prior to your visit to our office. Choose a 24-hour period to keep this record when you can conveniently measure every voiding, and begin your record with the first voiding upon rising.

EXAMPLE:

1. Time	2. Voided Volume	3. Leak Volume	4. Urge Present	5. Activity	6. Amount/Type Intake
6:45 ☑ AM ☐ PM	550 ☑ CC ☐ OZ	1 2 3	Yes No	Awakening	
7:00 ☑ AM ☐ PM	☐ CC ☐ OZ	1 2 3	Yes No	Turned on water	2 cups coffee 6 oz. OJ

1. **Time:** Record time of all voids, leakage, intake of liquids and activity.
2. **Voided:** Measure all intake and urine output in cc's or oz. (1 cup = 240 cc's)
3. **Leak Volume:** Estimate the amount of leakage according to the following scale:
   1 = damp, few drops only
   2 = wet underwear or pad
   3 = soaked or emptied bladder
4. **Urge Present:** If the urge to urinate is accompanied (or preceded the urine leakage) check "Yes."
   If you felt no urge when leaking occurred check "No."
5. **Activity:** Describe activity you were performing at the time of leakage. If you were not actively doing anything, record whether you were sitting, standing, or lying down.
6. **Activity/Type Intake:** Record the amount and type of liquid intake using either cc's or oz. (1 cup = 240 cc's)

Voiding Diary/Urlog

1. Time	2. Voided Volume	3. Leaked Volume	4. Urge Present	5. Activity	6. Amount/Type Intake
☐ AM ☐ PM	☐ CC ☐ OZ	1 2 3	Yes No		
☐ AM ☐ PM	☐ CC ☐ OZ	1 2 3	Yes No		
☐ AM ☐ PM	☐ CC ☐ OZ	1 2 3	Yes No		
☐ AM ☐ PM	☐ CC ☐ OZ	1 2 3	Yes No		
☐ AM ☐ PM	☐ CC ☐ OZ	1 2 3	Yes No		
☐ AM ☐ PM	☐ CC ☐ OZ	1 2 3	Yes No		
☐ AM ☐ PM	☐ CC ☐ OZ	1 2 3	Yes No		

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Voiding Diary/Urlog

1. Time	2. Voided Volume	3. Leaked Volume	4. Urge Present	5. Activity	6. Amount/Type Intake
☐ AM ☐ PM	☐ CC ☐ OZ	1 2 3	Yes No		
☐ AM ☐ PM	☐ CC ☐ OZ	1 2 3	Yes No		
☐ AM ☐ PM	☐ CC ☐ OZ	1 2 3	Yes No		
☐ AM ☐ PM	☐ CC ☐ OZ	1 2 3	Yes No		
☐ AM ☐ PM	☐ CC ☐ OZ	1 2 3	Yes No		
☐ AM ☐ PM	☐ CC ☐ OZ	1 2 3	Yes No		
☐ AM ☐ PM	☐ CC ☐ OZ	1 2 3	Yes No		
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☐ AM ☐ PM	☐ CC ☐ OZ	1 2 3	Yes No		

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