MEDICAL HISTORY QUESTIONNAIRE

Name_____ **Date**_____

In order to help us provide you with the best medical care, please complete this form in as much detail as possible. Please bring the completed form with you at the time of your first visit. DO NOT MAIL IT.

Please write, in your own words, the nature of your current gynecologic, colorectal or urologic medical problem.

_____

_____

_____

PLEASE FILL IN THE FOLLOWING INFORMATION: Age _____ Birthdate ___/___/___ Race/Ethnicity _____

Detailed History

BLADDER Symptoms

Do you have uncontrolled loss of urine with coughing, laughing or physical activity? Yes _____ No _____
If yes, for how long? _____
Do you often have a strong urge to urinate? Yes _____ No _____
Do you have uncontrolled loss of urine with urgency or on the way to the bathroom? Yes_____ No _____
If yes, for how long? _____
Do you use pads for urine leakage? Yes _____ No_____
If yes, what type of pad _____ How often do you change your pad per day?_____
On average, how often do you urinate during the day? _____times And at night? _____times
Do you experience a burning sensation when you urinate? Yes _____ No _____
Do you have blood in your urine? Yes _____ No _____
Do you have more than 3 bladder infections per year? Yes _____ No _____
Do you have difficulty urinating or do you strain with urination? Yes _____ No _____
Do you feel that your bladder does not empty completely? Yes _____ No _____
Do you have to push on a bulge in the vaginal area to empty your bladder? Yes _____ No _____

VAGINAL PROLAPSE Symptoms

Do you experience pelvic pressure, heaviness or dullness? Yes _____ No _____
Do you see or feel a bulge, or something falling out in the vaginal area? Yes _____ No _____

SEXUAL Symptoms

Do you have sexual relations with a partner? Yes _____ No _____
How long have you been with your current sexual partner? _____
Is your sex life satisfactory for you? Yes _____ No _____
Do you have any questions about sex you would like to ask? Yes _____ No _____
Have you been a victim of domestic violence or sexual abuse? Yes _____ No _____

BOWEL Symptoms

Do you have problems with:
diarrhea? Yes _____ No _____
constipation? Yes _____ No _____
fecal incontinence/leaking stool? Yes _____ No _____ If yes, for how long? _____
Do you leak solid stool? ____ loose/liquid stool? ____ gas? ____
Do you leak stool with coughing, laughing or physical activity? _____ with urgency? _____
anal/rectal bleeding? Yes _____ No _____
change in bowel habits? Yes _____ No _____
anal pain or hemorrhoids? Yes _____ No _____
Do you feel that your bowels do not empty completely after a bowel movement? Yes _____ No _____
Do you have to push on the vagina or around the rectum to empty your bowels? Yes _____ No _____
Frequency of bowel movements _____/day;_____/week
Have you had a colonoscopy? Yes _____ No _____ Date of last___/___/___ Results_____
Have you had prior surgery for prolapse or incontinence? Yes _____ No _____
If yes, what surgeries? _____

MEDICAL HISTORY QUESTIONNAIRE

GYNECOLOGIC HISTORY:

Age when periods first started _____
Date most recent menstrual period started ___/___/___
Number or days from the start of one period to the start of the next period _____
Are your periods regular? Yes _____ No _____
How long do your periods last? _____
Do you have bleeding between periods? Yes _____ No _____
Do you have bleeding after intercourse? Yes _____ No _____
Do you have heavy menstrual periods? Yes _____ No _____
Do you have pain with periods? Yes _____ No _____
Birth control method _____
Have you gone through menopause? Yes _____ No _____
If yes, at what age? _____
Are you taking estrogen replacement therapy? Yes _____ No _____
If yes, which one? Oral _____ Vaginal _____
Date of last Pap smear: ___/___/___ Normal: Yes _____ No _____
Date of last mammogram: ___/___/___ Normal: Yes _____ No _____
Have you had any treatment to your cervix? Yes _____ No _____ If yes, when?_____
Cautery _____ Cryosurgery _____ Other _____
Have you ever had a sexually transmitted infection? Yes _____ No _____ If yes, when? _____
Herpes _____ Chlamydia _____ Gonorrhea _____ Trichomonas _____
HIV _____ Condyloma/warts _____ Pelvic inflammatory disease/PID _____
Other _____
Have you had a hysterectomy? Yes _____ No _____ If yes, when and reason? _____
Abdominal _____ Vaginal _____ Laparoscopic _____
Have you had surgery to remove one or both ovaries? Yes _____ No _____

PAST OBSTETRICAL HISTORY:

Number of pregnancies _____
Number of children born alive _____
Number of miscarriages _____
Number of abortions _____
Number of ectopics (tubal) _____
Type of deliveries (number of each)
Vaginal _____
Cesarean (C/Section) _____
Forceps _____
Vacuum _____
Weight of largest vaginal delivery
_____ pounds _____ ounces
Tear into the rectum? Yes____ No____

PAST MEDICAL HISTORY: (Check if your answer is yes)

_____Heart Disease
_____Heart Murmur
_____Kidney Infection
_____Diabetes
_____Stroke
_____Anxiety
_____Depression
_____Cancer, type_____
_____Other_____
_____Liver Disease
_____Pneumonia
_____Thyroid Disease
_____Antibiotics before procedures
_____Arthritis
_____Multiple sclerosis
_____Parkinson's disease
_____Tuberculosis
_____Serious Injuries or accidents
_____High Blood Pressure
_____Asthma
_____Emphysema/COPD
_____Reflux/Indigestion
_____Ulcer (stomach, intestinal)
_____Any implantable devices

SURGICAL HISTORY: (Check if your answer is yes and give the date of the surgery)

Have you had any operations? Yes _____ No _____

_____Appendectomy
_____Breast surgery (biopsy, lumpectomy, mastectomy)
_____Exploratory laparotomy
_____Bowel or stomach surgery
_____Hip Surgery
_____Spine surgery
_____Thyroid surgery
_____Gall Bladder/Cholecystectomy
_____Breast plastic surgery
_____Diagnostic laparoscopy
_____Hernia repair
_____Knee surgery
_____Tonsillectomy
_____Other _____
_____

Have you had any blood transfusions? Yes_____ No _____ Any reaction? Yes _____ No _____

MEDICAL HISTORY QUESTIONNAIRE

FAMILY HISTORY

Has anyone in your family had any of these diseases? If so, please give relationship.

High blood pressure	_____	**Diabetes**	_____
Stroke	_____	**Breast Cancer**	_____
Bleeding Problems	_____	**Colitis**	_____
Heart disease	_____	**Colon/Rectal Cancer**	_____
Ovarian Cancer	_____	**Other Cancer**	_____

List other diseases_____

Father: _____Alive _____Deceased; if so, cause_____
Mother: _____Alive _____Deceased; if so, cause_____

SOCIAL HISTORY

Current marital status: Married_____ Single_____ Divorced_____ Widowed_____ Separated_____
Number of people living in your household_____
Your occupation_____

HEALTH HABITS

Do you smoke? Yes _____ No _____
If yes, how many packs per day? _____
If no, did you smoke in the past? Yes _____ No _____
If yes, how many packs per day? _____ **when did you quit?** _____
Do you use alcohol? Yes _____ No _____
Do you use drugs? Yes _____ No _____
Do you exercise regularly? Yes _____ No _____
If yes, what type of exercise do you do?_____

ALLERGIES

Do you have any allergies to medications? No_____ Yes_____
If yes, please list: _____
_____

MEDICATIONS

Please list all medicines which you are currently taking (including contraceptives, hormones, vitamins and over the counter medications.) Use a separate sheet if necessary.

MEDICATION:_____ **DOSAGE:**_____
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MEDICAL HISTORY QUESTIONNAIRE

Review of Symptom: Please check if any of the following symptoms apply:

Constitutional Symptoms
__fever
__chills
__loss of appetite
__weight loss
__weight gain
__other_____

Eyes
__blurred vision
__double vision
__eye pain
__other_____

Ear/Nose/Throat
__ear pain
__ringing in ears
__decreased hearing
__frequent bloody noses
__sore throat
__other_____

Breast
__breast lump
__nipple discharge
__breast pain
__other_____

Cardiovascular
__chest pain
__palpitations
__passing out/loss of consciousness
__swelling in legs
__other_____

Respiratory
__cough
__shortness of breath
__coughing up blood
__wheezing
__other_____

Gastrointestinal
__nausea
__vomiting
__abdominal pain
__black stools
__indigestion/heartburn
__other_____

Genitourinary
__vaginal discharge
__kidney stones
__other_____

Musculoskeletal
__neck pain
__back pain
__joint pain
__difficult walking
__other_____

Skin
__skin rash
__persistent itching
__change in any mole
__other_____

Neurologic
__weakness
__numbness/tingling
__seizures
__passing out/loss of consciousness
__tremors
__headaches
__other_____

Psychiatric
__depression
__anxiety
__psychiatric treatment
__other_____
__

Endocrine
__too cold
__too hot
__excessive thirst
__fatigue
__other_____

Hematologic/Lymphatic
__easy bruising
__bleeding
__swollen glands
__anemia/low blood count
__other_____

Allergic/Immunologic
__hives
__hay fever
__other_____

MEDICAL HISTORY QUESTIONNAIRE

BLADDER DIARY

- You may start the diary any day of the week, but please use it for 2 days in a row.
- Record the amount of fluid you drink each hour of the day in ounces or milliliters and the type of fluid (example coffee, tea, soda, etc.)
- Record each time you urinate by placing an **X** in the Toilet column next to the corresponding time.
- Record each time you accidentally lose urine, even if only a small amount, by placing an **X** in the Accident column next to the corresponding time each day.
- If needed, you can place more than one **X** in each box.
- For each day, write in the time when you get up, the time you go to bed and the number of pads you used at the bottom of the column.

	Day 1 Date ___/___/____			**Day 2** Date ___/___/____		
TIME	Fluid intake	Toilet	Accident	Fluid intake	Toilet	Accident
12-12:59 am						
1-1:59 am						
2-2:59 am						
3-3:59 am						
4-4:59 am						
5-5:59 am						
6-6:59 am						
7-7:59 am						
8-8:59 am						
9-9:59 am						
10-10:59 am						
11-11:59 am						
12-12:59 pm						
1-1:59 pm						
2-2:59 pm						
3-3:59 pm						
4-4:59 pm						
5-5:59 pm						
6-6:59 pm						
7-7:59 pm						
8-8:59 pm						
9-9:59 pm						
10-10:59 pm						
11-11:59 pm						
# Pads used						
Time woke up						
Time went to bed						