TriHealth
Women's Services
Cincinnati Urogynecology Associates

LAST NAME: ___________________________ FIRST NAME: __________________________ AGE: ___________
Date of appointment: __________________ Date of Birth: _______________________ Race: ____________________
Referring physician: _____________________________ Other Referral: ______________________________________
Chief Complaint (why you came to see the doctor):
____
____

PELVIC ORGAN SYMPTOMS:

BLADDER CONTROL PROBLEMS

Do you have problems with accidental loss of urine or urinary urgency/frequency? Y N
IF YOU ANSWERED YES, CONTINUE. IF NO, SKIP TO NEXT SECTION.
How many months or years have you had bladder problems? ____________Months _______________Years
Do you use pads to absorb lost urine? Y N If yes, how many pads do you wear in a day: __________
About how many trips do you make to the bathroom during the day? _____________
About how many times do you wake at night to go to the bathroom? _____________
Do you ever wet the bed while asleep? Y N
Are there times when you cannot make it to the bathroom in time? Y N
Does the sound, sight or feel of running water cause you to lose urine? Y N

Which best describes urine loss: (*check all that apply*)
□ I lose urine during coughing, sneezing, running, or lifting
□ I lose urine with changes in posture, standing, or walking
□ I lose urine continuously or without awareness such that I am constantly wet
□ I have sudden, urgent needs without the ability to make

Have you seen a physician for complaints of urine loss? Y N If yes, who? _________________________
Have you taken medication to prevent urine loss? Y N
If yes, what meds? ____
How many glasses of liquid do you consume daily? ____________________
How many drinks containing caffeine (coffee, tea, soda) do you consume daily? _________________

BLADDER EMPTYING PROBLEMS

Do you have problems with urinating or emptying your bladder completely? Y N
IF YOU ANSWERE YES, CONTINUE. IF NO, SKIP TO NEXT SECTION.
How long have you had bladder emptying problems? ________months _________years
Do you notice any dribbling of urine when you stand after passing urine? Y N
Do you usually have difficulty starting your urine stream? Y N
Do you have to assume abnormal positions to urinate? Y N
Do you have to strain to empty your bladder? Y N
Is your urine flow: Strong Weak Dribbling Intermittent
Do you feel as if your bladder is empty after passing urine? Y N

Name: ____________________
DOB: ____________________

PROLAPSE/VAGINAL SUPPORT PROBLEMS

Do you have a feeling of fullness or pressure, bulge or protrusion of any vaginal tissue? Y N
IF YOU ANSWERED YES, CONTINUE. IF NO, SKIP TO NEXT SECTION.
Do you notice a bulge? Y N
How long have you had a protrusion or bulge? ___________months __________years
Are your symptoms worse at the end of the day or after standing for prolonged periods? Y N
Do you push the protrusion back to help with a bowel movement or to empty your bladder? Y N
Have you ever used a pessary (a plastic support device) for this problem? Y N

BOWEL SYMPTOMS

Do you have problems with your bowels (bowel incontinence or difficulty emptying your bowels)? Y N
IF YOU ANSWERED YES, CONTINUE. IF NO, SKIP TO NEXT SECTION.
How long have you had bowel symptoms? _____________months ___________years
Do you have accidental loss of solid stool? Y N
Do you have accidental loss of liquid stool? Y N
Do you have accidental loss of gas? Y N
How long have you had accidental loss of stool or gas? __________months ___________years
How many episodes per week? ___________
Do you wear protective pads for this problem? Y N If yes, how many pads each day? ________
Do you have constipation? Y N Do you have diarrhea? Y N Problems with bloating? Y N
Do you have a frequent desire to have a bowel movement? Y N
Do you feel that your bowels are never completely empty? Y N
Do you ever place your fingers in your vagina or between the vagina and rectum to help with a bowel movement? Y N

SEXUAL HISTORY

Are you sexually active? Y N
If not sexually active, are barriers to sexual activity due to:
Prolapse (vaginal bulging) Y N
Incontinence Y N
Pain Y N

PELVIC PAIN

Do you have pain in your pelvic area? Y N
IF YOU ANSWERED YES, CONTINUE. IF NO, SKIP TO NEXT SECTION.
Where is your pain? □pelvic area □vagina □rectum □lower abdomen
How long have you had pelvic pain? _________months _________years
Is your pain relieved by bladder emptying? Y N
Do you have pain with urination? Y N
Are there any other measures that relieve pain? Y N If yes, what are they___________________________
Do you see a pain specialist? Y N If yes, who? ____

GYN HISTORY

Number of pregnancies _____________ Number of vaginal deliveries _____________ Number of c/sections ______________
Any complications such as: Lacerations Forceps Vacuum Episiotomy Weight of largest baby _____________
Provide one of the following: Last Menstrual Period _______________ **OR** Age at Menopause ________________
Date of last PAP smear test: ______________________ Was it normal? Y N
Date of last Mammogram: ______________________ Was it normal? Y N
Do you have a history of sexually transmitted disease(s)? Y N If yes, type?_____________________________

Name: ____________________
DOB: ____________________

MEDICAL HISTORY (Check all that apply)

______ Arthritis
______ Bleeding Disorder
______ Depression/Anxiety
______ Glaucoma
______ Kidney Stones
______ Pneumonia
______ Stroke
______ Ulcers
______ Asthma
______ Blood Clots
______ Diabetes
______ Hypertension
______ Liver Disease
______ Seizures/Convulsions
______ Thyroid Disease
______ Hepatitis A / B / C
______ Bladder infections
______ COPD
______ Fibromyalgia
______ Kidney Disease
______ Migraines
______ Sleep Apnea
______ Tuberculosis (Tb)
______ Heart Problems, *please specify* ____

Cardiologist Name:____
______ Cancer, *please specify* ____

______ Other ____

Do you see any other specialists? *Please provide name and specialty*____

SURGICAL HISTORY

Hysterectomy Date: _______________ **Reason**: ____ Prolapse ____ Fibroids ____ Bleeding ____ Endometriosis
Incision: ____Vaginal ____ Abdominal **Ovaries removed**? Y N

Bladder Repair Date: _______________ **Reason:** ____ Prolapse ____ Leakage
Incision: ____Vaginal ____ Abdominal
Result of surgery was: ____ Helped temporarily for _____mos/yrs ____ No Difference ____Made it worse

List all other surgeries:

___________________________ Date: ______________ ___________________________ Date: __________

___________________________ Date: ______________ ___________________________ Date: __________

___________________________ Date: ______________ ___________________________ Date: __________

FAMILY HISTORY *Check all that apply and indicate relationship of relative*

☐ Cancer (*specify site)* ______________________________
☐ Diabetes ______________________________
☐ Hypertension ______________________________
☐ Reactions to Anesthesia ______________________________
☐ Bleeding disorder ______________________________
☐ Heart Disease______________________________
☐ Stroke ______________________________
☐ Other ______________________________

SOCIAL HISTORY

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Alcohol use ☐ Never ☐ Rarely ☐ Occasionally ☐ Daily
Tobacco use ☐ Never ☐ Current ____packs/day for ____ years ☐ Quit *If so, when?*___________
How long did you smoke? ______
Drug use ☐ Never ☐ Recreational ☐ Daily Type:______________________________
Occupation ____

Does your occupation require heavy lifting? (> 25lbs) Y N

Review of Systems *Circle all that apply*

Fever	Chills	Recent weight change	Fatigue	Sweating	Weakness
Rash/Itching	Headache	Hearing Loss	Ringing in ears	Ear pain	Nosebleeds
Congestion	Sore throat	Blurred Vision	Double vision	Eye pain	Light sensitivity
Chest Pain	Palpitations	Short of breath	Leg pain	Leg swelling	Chronic cough
Coughing up blood	Wheezing	Heartburn	Nausea	Vomiting	Abdominal pain
Diarrhea	Constipation	Blood in stool	Neck/Back pain	Falls	Bruise easily
Environmental allergies	Excessive thirst	Dizziness	Numbness	Tremors	Fainting
Suicidal thoughts	Anxiety	Sleeping problems			

Other symptoms ____

____

DRUG ALLERGIES

☐ **No Known Allergies**

NAME	**REACTION**	**NAME**	**REACTION**

CURRENT PRESCRIPTION *AND* OVER THE COUNTER MEDICATIONS, VITAMINS & SUPPLEMENTS

Name	**Dose**	**Purpose/Indication**

☐ If more space is needed, please attach a complete list of medications.