New Patient Initial Medical and Surgical History and Symptom Inventory

Patient Identification

Last name ____

First name ____

Date of birth __ ___/ ___/ ___ ___ ___ ___ (mm/dd/yyyy)

Today's date __ ___/ ___/ ___ ___ ___ ___ (mm/dd/yyyy)

Your physicians:

In order for us to provide your personal physicians with our assessment and recommendations, please list your physician(s) below.

Primary physician:

Name: ____

Address: ____

City/State/Zip: ____

Phone number: ____

The physician who recommended this consultation (if different from above):

Name: ____

Address: ____

City/State/Zip: ____

Phone number: ____

Revised April 2006

Your medications

Please list all medications you are currently taking. This includes pills, injections, patch medications, creams, etc. Please include prescription medications as well as over-the-counter medications that you take regularly. Please also include "herbal" or alternative medications.

DRUG	**DOSE**	**HOW OFTEN**	**REASON**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Revised April 2006

Ethnicity

Do you consider your ethnicity to be Hispanic or Latino? Yes/no

For this question on racial background, you may select one or more choices:

Do you consider yourself to be:

White/Caucasian	Yes/no
Black/African American	Yes/no
Asian	Yes/no
Native Hawaiian/Pacific Islander	Yes/no
American Indian/Alaskan Native	Yes/no
Other	Yes/no
Refused	Yes/no

If more than one choice was selected, which do you consider to be your primary racial background?

(select the one that best describes your primary racial background)

- ☐ White/Caucasian
- ☐ Black/African American
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ American Indian/Alaskan Native
- ☐ Other
- ☐ Refused

Education

Please indicate your highest level of education (please pick one)

- ☐ Not answered
- ☐ Elementary school
- ☐ Junior high school
- ☐ High school
- ☐ College degree
- ☐ Graduate degree

Past Medical History:

Please indicate whether (to your knowledge) you have any of these conditions:

Condition	
Osteoarthritis	yes/no
Rheumatoid arthritis	yes/no
Lupus, Sjogrens, Fibromyalgia	yes/no
High blood pressure	yes/no
Peripheral vascular disease (claudication)	yes/no
Heart disease (angina) heart attack	yes/no
Congestive heart failure	yes/no
Stroke	yes/no
Abnormal heart rate	yes/no
Emphysema	yes/no
Asthma	yes/no
Diabetes mellitus	yes/no
Indigestion	yes/no
Ulcer, (stomach or intestinal)	yes/no
Constipation	yes/no
Liver disease	yes/no
Liver failure	yes/no
Kidney failure	yes/no
Kidney stones	yes/no

Cancer

Breast	yes/no
Colon	yes/no
Uterus	yes/no
Ovary	yes/no
Leukemia	yes/no
Lymphoma	yes/no

Other cancer ____

Injuries

Head	yes/no
Spine	yes/no
Pelvis	yes/no

Alzheimer's Dementia	yes/no
Parkinson's disease	yes/no
Multiple sclerosis	yes/no
Depression	yes/no
Paralysis	yes/no
HIV	yes/no
AIDS	yes/no

Other condition____

Past Gynecologic History

Please describe your gynecological history by answering the questions below:

Are you still having your period (menstruating} yes/no

If you are still having your period:

How often do you have your period (menses) (please pick one)

- □ Regularly (about once per month)
- □ Too frequently
- □ Infrequently

Is your flow? (please pick one)

- □ Normal
- □ Light
- □ Heavy

Do you have severe menstrual cramps? yes/no

Have you stopped having periods? yes/no

At what age ____ ____

Are you taking estrogen replacement therapy? (please pick one)

- □ None
- □ Continuous (same pill/pills every day)
- □ Cyclic

Have you had any of the following gynecologic surgeries?

Dilation and curettage yes/no

Hysteroscopy yes/no

Hysterectomy (please pick one)

- □ None
- □ Total abdominal hysterectomy
- □ Total vaginal hysterectomy
- □ Laparoscopic hysterectomy

Surgery on an ovary yes/no

Surgery to remove one or both ovaries yes/no

Tie tubes yes/no

Removal of tube yes/no

Have you had prior gynecologic cancer

Cervical cancer yes/no

Ovarian cancer yes/no

Uterine cancer yes/no

Vaginal cancer yes/no

Have you had prior radiation therapy yes/no

Past Surgical History

Please check all surgeries that you have undergone:

Surgery	
Appendectomy	yes/no
Breast surgery (biopsy, lumpectomy, or mastectomy	yes/no
Breast plastic surgery	yes/no
Cholecystectomy	yes/no
Diagnostic Laparoscopy	yes/no
Exploratory laparotomy	yes/no
Hernia repair	yes/no
Hernia repair (multiple)	yes/no
Hip surgery	yes/no
Knee surgery	yes/no
Nissan fundoplication	yes/no
Spine surgery	yes/no
Tonsilectomy	yes/no
Thyroid surgery	yes/no

Other surgery ____

Past Obstetrical History

Please describe your obstetrical history by answering the questions below:

Number of pregnancies ___ ___
- Number of vaginal deliveries ___ ___
- Of these vaginal deliveries, how many involved forceps or vacuum ___ ___
- Number of cesarean deliveries ___ ___
- Number of ectopic (tubal) pregnancies ___ ___
- Number of miscarriages ___ ___
- Number of abortions ___ ___

What was the weight of your largest child delivered vaginally (in pounds) ___ ___

Have you had at least one episiotomy or vaginal tear? yes/no/unknown

Have you had at least one tear unto rectum yes/no/unknown

Allergies Do you have any allergies to medicines? yes/no

If so please list the medications and the describe the allergic reaction:

____

____

____

____

____

Family History

Does anyone in your family have any of the following?

High blood pressure	yes/no
Heart disease (angina) of heart attack	yes/no
Stroke	yes/no
Diabetes mellitus	yes/no
Cancer	
Breast	yes/no
Colon	yes/no
Uterine	yes/no
Ovarian	yes/no

Social History

Are you married? yes/no

How would you describe your job and lifestyle (please pick one)

- ☐ Sedentary
- ☐ Active
- ☐ Strenuous
- ☐ Unsure

Choose the **maximum activity** you can perform in day to day life: (**please pick one**)

- ☐ Participate in strenuous sports like swimming, singles tennis, football, basketball or skiing
- ☐ Participate in moderate recreational activities like golf, dancing, doubles tennis or throwing a baseball or football
- ☐ Do heavy work around the house like scrubbing floors or lifting/moving heavy furniture
- ☐ Run a short distance
- ☐ Walk on level ground at 4 mph
- ☐ Climb a flight of stairs or walk up a hill
- ☐ Do light work around the house like dusting or washing dishes
- ☐ Walk a block or two on level ground at 2-3 mph
- ☐ Walk indoors around the house
- ☐ Eating, dressing, bathing or using the toilet without help
- ☐ I cannot do any of the above

Please describe your tobacco use (please pick one)

- ☐ Never
- ☐ Past
- ☐ Present

If you smoke cigarettes please list the number of

Packs/day ___

Years smoking ___ ___ ___

Review of Symptoms

Please check all symptoms that apply to you:

Symptom	
fatigue (tiredness)	yes/no
weight loss	yes/no
weight gain	yes/no
fever	yes/no
breast mass	yes/no
breast discharge	yes/no
hearing problems	yes/no
can't lie flat without getting short of breath	yes/no
chest pain	yes/no
passing out (fainting)	yes/no
need antibiotics before dental work	yes/no
cough	yes/no
coughing up blood	yes/no
shortness of breath	yes/no
nausea	yes/no
vomiting	yes/no
loss of appetite	yes/no
bleeding from rectum	yes/no
difficulty swallowing	yes/no
blood in urine	yes/no
joint pain	yes/no
leg swelling	yes/no
frequent headache	yes/no
difficulty seeing	yes/no
difficulty talking	yes/no
seizures	yes/no
weakness	yes/no
numbness, or pins and needles sensations	yes/no
abnormal bleeding	yes/no
low blood count (anemia)	yes/no

Bladder & Bowel Dysfunction

On average how many times do you urinate during waking hours? ___ ___

On average, how many times do you get up to urinate at night? ___ ___

On average, how many bowel movements do you have per week? ___ ___

Do you use pads for any of the following reasons besides menstrual flow?

Urinary incontinence yes/no

Fecal incontinence yes/no

Other yes/no

If you use pads for incontinence, what type of pads do you use? (please pick one)

- ☐ None
- ☐ Minipad
- ☐ Shield
- ☐ Diaper

If you use pads for incontinence, how many per 24 hours?

Number of pads per day ___ ___

Unique patient identifier *[office use only]* _______________

Pelvic Floor Distress Inventory - Short form 20 (PFDI-20)

Instructions:
Please answer these questions by putting a **X** in the appropriate box. If you are unsure about how to answer a question, give the best answer you can. While answering these questions, please consider your symptoms over the **last 3 months.**

1. Do you usually experience *pressure* in the lower abdomen? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

1 Not at All - **2** Somewhat - **3** Moderately - **4** Quite a bit

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2. Do you usually experience *heaviness or dullness* in the pelvic area? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

1 Not at All - **2** Somewhat - **3** Moderately - **4** Quite a bit

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3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

1 Not at All - **2** Somewhat - **3** Moderately - **4** Quite a bit

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4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

1 Not at All - **2** Somewhat - **3** Moderately - **4** Quite a bit

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5. Do you usually experience a feeling of incomplete bladder emptying? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

1 Not at All - **2** Somewhat - **3** Moderately - **4** Quite a bit

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6. Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

1		**2**		**3**		**4**
Not at All	-	Somewhat	-	Moderately	-	Quite a bit

7. Do you feel you need to strain too hard to have a bowel movement? ☐ No; ☐ Yes
0

If other than never, how much does this bother you?

1		**2**		**3**		**4**
Not at All	-	Somewhat	-	Moderately	-	Quite a bit

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8. Do you feel you have not completely emptied your bowels at the end of a bowel movement? ☐ No; ☐ Yes
0

If other than never, how much does this bother you?

1		**2**		**3**		**4**
Not at All	-	Somewhat	-	Moderately	-	Quite a bit

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9. Do you usually lose stool beyond your control if your stool is well formed? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

1		**2**		**3**		**4**
Not at All	-	Somewhat	-	Moderately	-	Quite a bit

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10. Do you usually lose stool beyond your control if your stool is loose or liquid? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

1		**2**		**3**		**4**
Not at All	-	Somewhat	-	Moderately	-	Quite a bit

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11. Do you usually lose gas from the rectum beyond your control? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

1		**2**		**3**		**4**
Not at All	-	Somewhat	-	Moderately	-	Quite a bit

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12. Do you usually have pain when you pass your stool? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

1 Not at All - 2 Somewhat - 3 Moderately - 4 Quite a bit

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13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement? ☐ No; ☐ Yes
0

If other than never, how much does this bother you?

1 Not at All - 2 Somewhat - 3 Moderately - 4 Quite a bit

14. Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

1 Not at All - 2 Somewhat - 3 Moderately - 4 Quite a bit

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15. Do you usually experience frequent urination? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

1 Not at All - 2 Somewhat - 3 Moderately - 4 Quite a bit

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16. Do you usually experience urine leakage associated with a feeling of urgency, that is a strong sensation of needing to go to the bathroom? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

1 Not at All - 2 Somewhat - 3 Moderately - 4 Quite a bit

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17. Do you usually experience urine leakage related to coughing, sneezing, or laughing? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

1 Not at All - 2 Somewhat - 3 Moderately - 4 Quite a bit

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18. Do you usually experience small amounts of urine leakage (that is, drops)? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

1		2		3		4
Not at All	-	Somewhat	-	Moderately	-	Quite a bit

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19. Do you usually experience difficulty emptying your bladder? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

1		2		3		4
Not at All	-	Somewhat	-	Moderately	-	Quite a bit

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20. Do you usually experience *pain* or *discomfort* in the lower abdomen or genital region? ☐ No; ☐ Yes
0

If yes, how much does this bother you?

1		2		3		4
Not at All	-	Somewhat	-	Moderately	-	Quite a bit

Pelvic Floor Impact Questionnaire – Short form 7 (PFIQ 7)

Instructions: Some women find that bladder, bowel or vaginal symptoms affect their activities, relationships, and feelings. For each question, place **"X"** in the response that best describes how much your activities, relationships or feelings have been affected by your bladder, bowel or vaginal symptoms or conditions **over the last 3 months**. Please be sure to mark an answer in **all 3 columns** for each question. Thank you for your cooperation.

How do symptoms or conditions related to the following usually affect your:

1. ability to do household chores (cooking, housecleaning, laundry)?

Bladder or *urine*	***Bowel or rectum***	***Vagina or Pelvis***
Not at all Somewhat Moderately Quite a bit	Not at all Somewhat Moderately Quite a bit	Not at all Somewhat Moderately Quite a bit

2. ability to do physical activities such as walking, swimming or other exercise?

Bladder or *urine*	***Bowel or rectum***	***Vagina or Pelvis***
Not at all Somewhat Moderately Quite a bit	Not at all Somewhat Moderately Quite a bit	Not at all Somewhat Moderately Quite a bit

3. entertainment activities such as going to a movie or concert?

Bladder or *urine*	***Bowel or rectum***	***Vagina or Pelvis***
Not at all Somewhat Moderately Quite a bit	Not at all Somewhat Moderately Quite a bit	Not at all Somewhat Moderately Quite a bit

4. ability to travel by car or bus for a distance greater than 30 minutes away from home?

Bladder or *urine*	***Bowel or rectum***	***Vagina or Pelvis***
Not at all Somewhat Moderately Quite a bit	Not at all Somewhat Moderately Quite a bit	Not at all Somewhat Moderately Quite a bit

5. participating in social activities outside your home?

Bladder or *urine*	***Bowel or rectum***	***Vagina or Pelvis***
Not at all Somewhat Moderately Quite a bit	Not at all Somewhat Moderately Quite a bit	Not at all Somewhat Moderately Quite a bit

6. emotional health (nervousness, depression)?

Bladder or *urine*	***Bowel or rectum***	***Vagina or Pelvis***
Not at all Somewhat Moderately Quite a bit	Not at all Somewhat Moderately Quite a bit	Not at all Somewhat Moderately Quite a bit

7. feeling frustrated?

Bladder or *urine*	***Bowel or rectum***	***Vagina or Pelvis***
Not at all Somewhat Moderately Quite a bit	Not at all Somewhat Moderately Quite a bit	Not at all Somewhat Moderately Quite a bit

<u>Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire</u>

1. (PISQ1)How frequently do you feel sexual desire? This feeling may include wanting to have sex, feeling frustrated due to lack of sex, etc.

0	1	2	3	4
Daily	Weekly	Monthly	Less than once a month	Never

2. (PISQ1A)Do you have sexual relations with a partner? Yes / no

3. (PISQ 2)Do you climax (have an orgasm) when having <u>sexual intercourse</u> with your partner?

0	1	2	3	4
Always	Usually	Sometimes	Seldom	Never

4. (PISQ 3)Do you feel sexually excited (turned on) when having sexual activity with your partner?

0	1	2	3	4
Always	Usually	Sometimes	Seldom	Never

5. (PISQ 4) How satisfied are you with the variety of sexual activities in your current sex life?

0	1	2	3	4
Always	Usually	Sometimes	Seldom	Never

6. (PISQ 5)Do you feel pain during sexual intercourse?

4	3	2	1	0
Always	Usually	Sometimes	Seldom	Never

7. (PISQ 6)Are you incontinent of urine (leak urine) with sexual activity?

4	3	2	1	0
Always	Usually	Sometimes	Seldom	Never

8. (PISQ 7)Does fear of incontinence (stool or urine) restrict your sexual activity?

4	3	2	1	0
Always	Usually	Sometimes	Seldom	Never

9. (PISQ 8)Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum, or vagina falling out?).

4	3	2	1	0
Always	Usually	Sometimes	Seldom	Never

10. (PISQ 9) When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame, or guilt?

4	3	2	1	0
Always	Usually	Sometimes	Seldom	Never

11. (PISQ 10)Does your partner have a problem with erections that affects your sexual activity?

4	3	2	1	0
Always	Usually	Sometimes	Seldom	Never

12. (PISQ 11)Does your partner have a problem with premature ejaculation that affects your sexual activity?

4	3	2	1	0
Always	Usually	Sometimes	Seldom	Never

13. (PISQ 12) Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?

4	3	2	1	0
Much less intense	Less intense	Same intensity	More intense	Much more intense