Hackensack Meridian *Health*

UROGYNECOLOGY

Thank you for taking the time to fill out this questionnaire. A detailed and accurate health history will enable us to give you the best care and treatment.

NAME **AGE** **DATE**

In your own words, please write the nature of your medical problem for which you are being seen today._____
_____
_____
_____
_____
_____
_____

BLADDER SYMPTOMS

Mark "T" for true and "F" for false, whichever is most accurate:

I leak urine____ If, true for how long have you been leaking urine? _____

I have to wear pads because of losing urine. ____ If so, how many pads do you use each day? _____

My bladder problem is bad enough that I would request surgery to fix it. ____

I have had bladder surgery. ___ If, true please how the surgery was performed.

_____Abdominally ____ Vaginally

The bladder surgery I had cured my problem. _____.

The bladder surgery fixed my problem for a period of time ___. If true, for how long? _____.

The bladder surgery did not help at all. _____.

I leak urine when I cough, sneeze, exercise or move suddenly. _____

I lose urine in small spurts. _____

I lose large amounts of urine and once leakage begins I cannot control it. _____

Physician: _____ Date: _____

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UROGYNECOLOGY

BLADDER SYMPTOMS – CONTINUED

PLEASE check all that apply

___ If I cough hard, I leak urine at the same time.

___ If I cough hard, the leaking comes a few seconds later.

___ I lose urine with sexual intercourse.

___ I often feel the urge and need to urinate even if my bladder isn't full.

___ The sound, sight, or feel of running water gives me the urge to urinate.

___ If I suddenly stand up after sitting or lying down, I lose urine.

___ I am not aware that I am loosing urine until I notice that I am wet.

___ I urinate more than eight times a day.

___ The need to urinate routinely wakes me up at least two times during the night.

___ I have had two or more bladder infections in the last year.

___ Intercourse causes me to have bladder infections.

___ I have pain in the area of my bladder.

___ I have pain when I urinate.

___ I have been treated by urethral dilation.

___ I had trouble with wetting the bed as a child.

___ I have trouble with wetting the bed now.

___ My urine loss is a continual drip, so that I am constantly wet.

___ I have trouble starting the urine stream.

___ My urine stream is no more than a dribble.

___ It takes me a long time to empty my bladder.

___ After I urinate, I often feel that I have not completely emptied.

BOWEL SYMPTOMS

Circle the one best answer to each of the following questions:

How often are you troubled with soiling yourself with solid bowel movement?

Never **Less than 2 times a month** **2 or more times a month**

How often are you troubled with soiling yourself with loose bowel movement?

Never **Less than 2 times a month** **2 or more times a month**

Do you frequently pass gas when you don't want to? **Yes** **No**

Physician: _____ Date: _____

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UROGYNECOLOGY

BOWEL SYMPTOMS - CONTINUED

How often are you constipated?

Never **Less than 2 times a month** **2 or more times a month**

Do you have a bowel movement at least twice a week? **Yes** **No**

How often do you have to bear down very hard to empty your bowels?

Up to 100% of the time **Up to 75% of the time** **Up to 50% of the time**

Up to 25% of the time **Never**

How often do you feel your bowels are not completely empty?

Up to 100% of the time **Up to 75% of the time** **Up to 50% of the time**

Up to 25% of the time **Never**

How often do you have to use your hands or fingers to help empty out your bowels?

Up to 100% of the time **Up to 75% of the time** **Up to 50% of the time**

Up to 25% of the time **Never**

How often do you find small amounts of smearing on your underwear?

Up to 100% of the time **Up to 75% of the time** **Up to 50% of the time**

Up to 25% of the time **Never**

Are you troubled with hemorrhoids? **Yes** **No**

Have you recently had a significant change in bowel habits? **Yes** **No**

Has the size of caliber of stool recently changed? **Yes** **No**

Have you recently had any black or "tarry" stools? **Yes** **No**

Have you recently had any bright red bleeding with bowel movements? **Yes** **No**

Are your bowel movements painful? **Yes** **No**

MEDICATIONS

What medications do you take regularly? Please include birth control and other hormones. Please list dosages: _____

_____

_____

_____

Please list any herbal or vitamin supplements:

_____

_____

ALLERGIES

Drug allergies and reactions:

_____

_____

Physician: _____ **Date:** _____

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UROGYNECOLOGY

MEDICAL HISTORY/REVIEW OF SYSTEMS

CONSTITUTIONAL SYMPTOMS			EYES			EARS,NOSE,THROAT,MOUTH		
Fever	Y	N	Blurred vision	Y	N	Ear infections	Y	N
Chills	Y	N	Double vision	Y	N	Sore throat	Y	N
Headache	Y	N	Eye pain	Y	N	Sinus problems	Y	N
Other	Y	N	Other	Y	N	Other	Y	N
SKIN			**ALLERGIC/IMMUNOLOGIC**			**BLOOD**		
Rash	Y	N	Hay Fever	Y	N	Easy bruising	Y	N
Persistent itch	Y	N	Drug Allergies	Y	N	Bleeding tendencies	Y	N
Discoloration	Y	N	Immune Disease	Y	N	Swollen glands	Y	N
Other	Y	N	Other	Y	N	Other	Y	N
CARDIOVASCULAR			**LUNGS**			**ENDOCRINE**		
Chest pain	Y	N	Wheezing	Y	N	Diabetes	Y	N
Hypertension	Y	N	Frequent cough	Y	N	Too hot/Too cold	Y	N
Leg clots	Y	N	Short of breath	Y	N	Tired/Sluggish	Y	N
Heart valves	Y	N	Other	Y	N	Thyroid Disease	Y	N
NEUROLOGICAL			**INTESTINAL**			**MUSCULAR/JOINT**		
MS/Parkinson's	Y	N	Abdominal pain	Y	N	Bone pain	Y	N
Fainting spells	Y	N	Nausea/Vomiting	Y	N	Joint pain	Y	N
Strokes	Y	N	Heartburn	Y	N	Back pain	Y	N
Spine surgery	Y	N	Other	Y	N			
UROLOGIC			**PSYCHOLOGIC**					
Urinary retention	Y	N	Depression	Y	N			
Pain	Y	N	Severe Anxiety	Y	N			
Frequency	Y	N						
Other	Y	N						

What is the most vigorous activity you do? _____

Please list any medical problems that you may have.

_____

_____

_____

Do you have a heart condition, heart murmur or mitral valve prolapse? Yes No

Do you require antibiotics before dental or surgical procedures? Yes No

Do you have a history of back problems? Yes No

If yes, please describe _____

Have you ever had any blood transfusions? Yes No

Physician: _____ Date: _____

OBSTETRICS AND GYNECOLOGY

Number of pregnancies: _____ Number of vaginal deliveries _____

Date of your last menstrual period: _____

Have you ever been on estrogen replacement therapy? Yes No

Are you planning to have more children? Yes No

Do you have any of the following? (Please check off any that you may have had)

___ Bleeding between periods ___Bleeding after intercourse

___ Heavy menstrual periods ___ Pain with period

Date of your last pap smear? _____ Was it normal? Yes No

Date of you last mammogram? _____ Was it normal? Yes No

Have you had any screening for Colon Cancer such as hemoccult, sigmoidoscopy, colonoscopy, barium enema? Yes No

If yes, Date: _____ Result: _____

Are you sexually active at the present time? Yes No

Do you have pain with intercourse? Yes No

Do you have trouble with pelvic pain? Yes No

Do you have trouble with "falling" of organs? Yes No

SURGICAL HISTORY

Please check off any surgeries you have had and list the year you had the surgery.

___ Abdominal Hysterectomy	**___ A&P repair**	**___ Bone/Joint surgery**
___ Vaginal Hysterectomy	**___ Bladder surgery**	**___ Gallbladder surgery**
___ Ovaries removed	**___ Back surgery**	**___ Appendectomy**
___ Hernia surgery	**___ Heart surgery**	**___ Hemorrhoidectomy**

List any other surgeries you have had which are not listed above:

_____

_____

_____

Physician: _____ Date:_____

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UROGYNECOLOGY

PERSONAL HISTORY

What is your height? __ _____ **Weight _____**

Do you smoke? Yes No **If yes, how many packs per day? _____**

Do you drink alcohol? Yes No **If yes, how many drinks per night? ___**

Do you drink caffeine? Yes No **If yes, how many servings per day? ___**

Do you exercise regularly? Yes No **Do you sleep regularly? Yes No**

Are you currently employed? Yes No **Do you live alone? Yes No**

What is your job activity? _____

Does your job/activity require heavy lifting? _____

How far away (minutes drive) do you live from our office? _____

FAMILY HISTORY

Has anyone in your family ever had: (check all that apply)

___ High Blood Pressure ___ Stroke ___ Colon Cancer ___ Diabetes ___ Breast Cancer

___ Ovarian Cancer ___ Other Cancer (please describe) _____

Please list any other diseases present in your family and which member had them.

_____

_____

_____

DO NOT WRITE IN THIS SPACE:

location quality severity duration timing context modfact _____

_____

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Physician: _____Date:_____