

# UROGYNECOLOGY MEDICAL HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_ Age \_\_\_ LMP \_\_\_\_\_ Date: \_\_\_\_\_

Pregnancies \_\_\_ Births (Vaginal \_\_\_ C/S \_\_\_) Term \_\_\_ Preterm \_\_\_ Miscarriage/Abortion \_\_\_  
Living \_\_\_

Weight of largest vaginal delivery \_\_\_\_\_

Allergies: \_\_\_ None \_\_\_ Yes \_\_\_\_\_ Reaction \_\_\_\_\_  
(Use the back of this page if necessary)

Referring Physician: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

**CHIEF COMPLAINT:** (The reason you want to see the doctor, what is bothering you most)

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## Pelvic Surgery, Appearance or Function Questionnaire

**\_\_\_ I have no problems with function or appearance of my vaginal/pelvic area. Skip this section.**

- |   |   |   |
|---|---|---|
| Y | N | I have had difficult births.                                |
| Y | N | I have a feeling of vaginal fullness or pressure.           |
| Y | N | I can see or feel a bulge protruding from my vagina.        |
| Y | N | I push the bulge back for a BM and/or to empty my bladder.  |
| Y | N | I have pelvic heaviness.                                    |
| Y | N | My vagina feels loose.                                      |
| Y | N | Sex is uncomfortable at times.                              |
| Y | N | I have pain/difficulty with sex due to my labia.            |
| Y | N | My labia interfere with urination.                          |
| Y | N | My labia rub, tug or pull on my clothing.                   |
| Y | N | I have difficulty wearing certain clothing due to my labia. |
| Y | N | I have concerns about the appearance of my genital region.  |

## BLADDER SYMPTOM QUESTIONNAIRE

     I have no bladder or urinary problems. Skip this section.

- Y    N    I leak urine. If Yes, how long have you been leaking urine? \_\_\_\_\_mo/yrs
- Y    N    I wear pads because of leaking urine. If Yes, number per day. \_\_\_\_\_
- Y    N    My bladder problem is bad enough that I would have surgery to fix it.
- Y    N    I have had an operation on my bladder. If Yes, how was the operation performed? \_\_\_\_\_vaginally \_\_\_\_\_abdominally
- Y    N    The operation on my bladder helped for a while. How long? \_\_\_\_\_
- Y    N    The operation on my bladder did not help at all.
- Y    N    I leak urine when I cough, sneeze, exercise, or move suddenly.
- Y    N    I leak urine in small spurts.
- Y    N    I leak urine in large amounts and once it starts I cannot control it.
- Y    N    If I cough hard I leak at the same time.
- Y    N    If I cough hard the leak comes a few seconds later.
- Y    N    I leak urine during sexual intercourse.
- Y    N    I feel the urge and need to urinate even if my bladder is not very full.
- Y    N    The sight, sound, or feel of running water gives me a strong urge to urinate
- Y    N    If I stand quickly from sitting or lying, I leak urine.
- Y    N    I am not aware I am losing urine until I notice I am wet.
- Y    N    I urinate more than 8 times per day.
- Y    N    The need to urinate wakes me up 2 or more times during the night.
- Y    N    I have had 2 or more bladder infections in the past year.
- Y    N    Intercourse causes me to have bladder infections.
- Y    N    It hurts to urinate.
- Y    N    I have pain in the area of my bladder.
- Y    N    My urine loss is a continual drip so that I am constantly wet.
- Y    N    After I urinate, I often feel I have not completely emptied my bladder.
- Y    N    It takes me a long time to empty my bladder.
- Y    N    My urine stream is no more than a dribble.
- Y    N    I have trouble starting the urine stream.
- Y    N    I have been treated with urethral dilation.
- Y    N    I had trouble wetting the bed as a child.
- Y    N    I have trouble wetting the bed now.

## BOWEL SYMPTOM QUESTIONNAIRE

     I have no bowel problems. Skip this section.

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

1. How often are you troubled with soiling yourself with solid stool?
- Never                  Fewer than 2 times/month                  2 or more times/month

2. How often are troubled with soiling yourself with loose stool?  
     Never              Fewer than 2 times/month              2 or more times/month
  3. How often are you constipated?  
     Never              Fewer than 2 times/month              2 or more times/month
  4. How often do you have to bear down hard for a bowel movement?  
     Never              25% of the time              50% of the time              75%      100%
  5. How often do you feel you are not completely empty after a bowel movement?  
     Never              25% of the time              50% of the time              75%      100%
  6. How often do you have to use your hands or fingers to help with bowel movements?  
     Never              25% of the time              50% of the time              75%      100%
  7. How often do you find small amounts of smearing in your underwear?  
     Never              25% of the time              50% of the time              75%      100%
- Y**    **N**    Do you frequently pass gas when you don't want to?  
**Y**    **N**    Do you have a bowel movement at least twice a week?  
**Y**    **N**    Are you bothered by hemorrhoids?  
**Y**    **N**    Have you recently had a significant change in your bowel habits?  
**Y**    **N**    Has the size or caliber of your stool recently changed?  
**Y**    **N**    Have you recently had any black or "tarry" stools?  
**Y**    **N**    Have you recently had any bright red bleeding with bowel movements?  
**Y**    **N**    Are your bowel movements painful?

## GYNECOLOGIC QUESTIONNAIRE

1. **Y**    **N**    Do you have menstrual periods? If yes, date of start of last period \_\_\_\_\_
2. If you have periods, are they: (circle all that apply)  
     Regular              irregular              heavy    moderate              scant              painful
3. If irregular, for how long? \_\_\_\_\_ months \_\_\_\_\_ years
4. If painful, does pain occur **before**, **during**, or **after** menses? (circle)
5. If you no longer have periods:  
     **Y**    **N**    Hysterectomy?  
     **Y**    **N**    Removal of the ovaries?  
     **Y**    **N**    Do you take or have you taken hormone replacement?
6. When was your last Pap smear? \_\_\_\_\_ Normal    Abnormal (circle)
7.    **Y**    **N**    Have you had treatments for abnormal Paps? If yes, explain: \_\_\_\_\_
8.    **Y**    **N**    Are you having any abnormal vaginal discharge or discomfort?

**MEDICAL HISTORY**

- None
- Diabetes
- Asthma
- Cancer
- HIV
- Depression/Anxiety
- Psychiatric problems
- Liver problems
- Thyroid problems
- Breast problems
- High blood pressure
- Heart disease
- Blood transfusions
- Kidney disease
- Varicose veins
- Trauma/Violence
- Anesthesia complications
- Breast problems
- Sexually transmitted disease
- Abnormal Pap
- Blood clots
- Digestive
- TB
- Glaucoma
- Stroke
- Other

**SURGICAL HISTORY**

- None
- C-section. How many? \_\_\_\_\_
- Appendectomy
- Hysterectomy.  Abdominal  Vaginal
- Ovaries removed.  Both  Right  Left
- Incontinence surgery. Type: \_\_\_\_\_
- Prolapse surgery. Type: \_\_\_\_\_
- Abdominal surgery. Type: \_\_\_\_\_
- Hernia surgery. Type: \_\_\_\_\_
- Tubal ligation  D&C  Back surgery  Hip surgery  Foot surg
- Diagnostic laparoscopy  Tonsils  Gallbladder

**FAMILY HISTORY (Significant problems)**

- Paternal Grandfather  None \_\_\_\_\_
- Paternal Grandmother  None \_\_\_\_\_
- Maternal Grandfather  None \_\_\_\_\_
- Maternal Grandmother  None \_\_\_\_\_
- Father  None \_\_\_\_\_
- Mother  None \_\_\_\_\_
- Brother  None \_\_\_\_\_
- Sister  None \_\_\_\_\_
- Other  None \_\_\_\_\_

**SOCIAL HISTORY**

- Marital status: S M W D (circle)
- Occupation:  Not working  Working. What occupation \_\_\_\_\_
- Tobacco:  Never or Daily amount \_\_\_\_\_ Number of years \_\_\_\_\_
- Alcohol  Never or Daily amount \_\_\_\_\_ Type \_\_\_\_\_
- Drug use.  Never or Type \_\_\_\_\_
- Abuse  Never or Describe \_\_\_\_\_
- Exercise  Daily  Couple of times/week  Weekly

Y N Are you sexually active?

Are your partner(s) (circle) Men Women Both

Y N Are you or your partner using birth control now?

If so, what method? (circle)

Condom Pill IUD Surgical Spermicide Implant Rhythm Injection Inserts None N/A

Y N Are you satisfied with this method?

Y N Do you need birth control?

**MEDICATIONS (use the back of this page if necessary)**

Medication	Dosage	Frequency Taken
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- 1.
- 2.
- 3.
- 4.
- 5.

**ALLERGIES**

None  Penicillin  Sulfa  IV Dye  Iodine/Betadine

Other w/reaction \_\_\_\_\_

**ROS – CIRCLE ANY SYMPTOMS YOU CURRENTLY HAVE**

General	<input type="checkbox"/> None	Fever Chills Weight Loss Fatigue Weakness Loss of appetite
Skin	<input type="checkbox"/> None	Rash Itching Hair loss Non-healing sores
Ears, Nose, Throat	<input type="checkbox"/> None	Headache Hearing loss Ringing in ears Earache Ear discharge Nosebleeds Congestion Sore throat Bleeding gums Hearing aid
Eyes	<input type="checkbox"/> None	Blurring Double vision Sensitivity to light Eye pain Eye discharge Eye redness Excess tearing Vision loss Cataracts Glaucoma Glasses Contacts
Heart	<input type="checkbox"/> None	Chest pain Palpitations Breathing discomfort when lying Muscle pain when walking Leg swelling Murmur Fainting Varicose veins/Phlebitis
Lungs	<input type="checkbox"/> None	Cough Coughing blood Sputum production Shortness of breath Wheezing Bronchitis Asthma
GI	<input type="checkbox"/> None	Heartburn Nausea Vomiting Abdominal pain Diarrhea Constipation Bloody stools Dark tarry stools Involuntary loss of gas or stool
GU	<input type="checkbox"/> None	Burning with urination Urinary urgency Frequency Bloody urine Flank pain Abnormal vaginal discharge Abnormal vaginal bleeding Vaginal dryness Involuntary urine loss
Muscles Skeleton	<input type="checkbox"/> None	Muscle aches Neck pain Back pain Joint pain Falls Stiffness Weakness Cramps
Endocrine	<input type="checkbox"/> None	Easy bruising/bleeding Environmental allergies Excessive thirst/sweating Hot flashes Weight gain/loss Loss of height
Heme/Lymph	<input type="checkbox"/> None	Anemia Transfusions
Immune	<input type="checkbox"/> None	Hay fever Persistent infections Seasonal allergies HIV exposure
Neurological	<input type="checkbox"/> None	Dizziness Tingling Tremor Sensory changes Speech changes Weakness Seizures Vertigo Convulsions Blackouts Vertigo
Phych	<input type="checkbox"/> None	Depression Thoughts of suicide Substance abuse Hallucinations Nervous/Anxiety Insomnia Mood swings Memory loss

