alaska women's health pc

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BIOGRAPHIC INFORMATION

Name: _____ Date: _____

Age: _____ Race: _____ Date of Birth: _____ Height: _____ Weight: _____

Reason for your visit

_____
_____
_____
_____

Your current address and phone number

_____
_____
_____
_____

REFERRAL INFORMATION

Referring Doctor or Nurse and Address/Phone

_____
_____
_____
_____

Primary Doctor or Nurse and Address/Phone

_____
_____
_____
_____

SYMPTOM QUESTIONNAIRE

In order to understand the nature of your pelvic floor concerns more clearly, we ask that you please answer the following questions. Each question tries to uncover specific aspects of incontinence or pelvic prolapse, and will help us make a diagnosis and treatment plan.

Section 1:

1. When I need to urinate, I experience an urgency so intense that I must rush to the toilet:
   ☐ always ☐ often ☐ half the time ☐ rarely ☐ never
2. I experience leakage of urine. ☐ Yes ☐ No **(if no, go to question 6)**
   How long have you experienced leakage of urine? _____ years _____ months
3. I leak urine when I do the following things **(check all that apply)**:
   ☐ cough ☐ sneeze ☐ lift ☐ bend over ☐ laugh ☐ walk ☐ run ☐ none of these
   How often? _____ times per ☐ day ☐ week ☐ month
4. I leak urine when I do the following things **(check all that apply)**:
   ☐ hear running water ☐ unlock the door ☐ go into cold weather
   ☐ rush to the toilet when I have a strong urge to urinate
   ☐ none of these
   How often? _____ times per ☐ day ☐ week ☐ month
5. I leak urine for no reason at all.
   ☐ always ☐ often ☐ half the time ☐ rarely ☐ never
6. During the day I urinate every _____ ☐ minutes ☐ hours.

SYMPTOM QUESTIONNAIRE CONTINUED

		Always	Often	Half the time	Rarely	Never
7.	My bladder awakens me at night to urinate.	☐	☐	☐	☐	☐
8.	When I am finished urinating, my bladder feels empty.	☐	☐	☐	☐	☐
9.	I need to push hard to empty my bladder.	☐	☐	☐	☐	☐
10.	I do Kegel exercises.	☐	☐	☐	☐	☐

Section 2:

1.	I feel as if there is something bulging into my vagina or coming out of my vagina.	☐	☐	☐	☐	☐
2.	I experience pelvic discomfort when standing or during physical exertion.	☐	☐	☐	☐	☐
3.	I have to push on the vaginal walls to empty my bladder.	☐	☐	☐	☐	☐
4.	I use a pessary.	☐	☐	☐	☐	☐

Section 3:

1.	I feel an urge when I need to have a bowel movement.	☐	☐	☐	☐	☐
2.	When I need to have a bowel movement, the urge is so intense that I must rush to the toilet.	☐	☐	☐	☐	☐
3.	I often have the urge to have a bowel movement and am unable.	☐	☐	☐	☐	☐
4.	I feel that having a bowel movement does not completely empty my rectum.	☐	☐	☐	☐	☐
5.	I use my fingers in my vagina or rectum to help with bowel movements.	☐	☐	☐	☐	☐
6.	If I have to pass gas, I can hold it for a short time.	☐	☐	☐	☐	☐
7.	Stool comes out when I am not on the toilet.	☐	☐	☐	☐	☐
8.	I have trouble with constipation.	☐	☐	☐	☐	☐
9.	I have _____ bowel movements per ☐ day ☐ week.					

Section 4:

1. I am sexually active. ☐ Yes ☐ No
2. Sexual intercourse is painful for me. ☐ ☐ ☐ ☐ ☐
3. In my life, I have been sexually or physically abused. ☐ Yes ☐ No
4. I leak urine with sexual relations. ☐ ☐ ☐ ☐ ☐
   If yes, this has affected my sexual interest. ☐ Yes ☐ No
5. I have other questions about sexual intercourse. ☐ Yes ☐ No

OTHER SYMPTOMS

Currently you are having problems with (check symptoms):

General:	☐ fevers	☐ chills	☐ decreased energy	☐ weight loss
Eyes:	☐ visual disturbances	☐ problems with glaucoma		☐ dry eyes
Ears,nose,throat:	☐ sinus problems	☐ chronic colds		
Cardiovascular:	☐ high blood pressure	☐ palpitations	☐ chest pain	☐ swelling in legs
Respiratory:	☐ shortness of breath	☐ chronic cough		☐ asthma
Gastrointestinal:	☐ diarrhea	☐ constipation	☐ heartburn	☐ bleeding
Musculoskeletal:	☐ joint pain	☐ back pain		
Emotional:	☐ depression	☐ anxiety	☐ mental changes	☐ emotional changes
Endocrine:	☐ excessive thirst	☐ hot spells or difficulty staying warm		
Hematologic:	☐ excessive bruising	☐ bleeding	☐ blood clots in veins	

Other: _____

OBSTETRIC AND GYNECOLOGIC HISTORY

Number of pregnancies: _____

Number of children born: _____

Number of cesarean sections: _____

Weight of largest infant: _____

During your deliveries, did you ever have a tear into the rectum?	☐ Yes	☐ No
Were forceps or a vacuum ever used?	☐ Yes	☐ No
Have you experienced menopause?	☐ Yes	☐ No
If yes, are you taking hormone replacement?	☐ Yes	☐ No
If no:		
Date of last menstrual period _____		
Are you having problems with your periods?	☐ Yes	☐ No
Date of last pap smear		
Was it normal?	☐ Yes	☐ No
Date of last mammogram _____		
Was it normal?	☐ Yes	☐ No
Date of last colon screening (colonoscopy/sigmoidoscopy) _____		
Was it normal?	☐ Yes	☐ No

SURGICAL HISTORY

List all surgeries and the approximate dates:

Surgery:	Date:

MEDICAL HISTORY

Do you have a history of any of these conditions?

- ☐ Heart disease
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Diabetes
- ☐ Stroke
- ☐ Parkinson's Disease
- ☐ Liver disease
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Multiple Sclerosis
- ☐ Cancer
- ☐ Glaucoma
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Thyroid disease
- ☐ Bowel disease

Other: _____

What medications are you currently taking? (Please include all over the counter medicines, herbs, remedies, and supplements.)

Medication	Dose

List any medications that you are allergic to: _____

Latex allergy? ☐ Yes ☐ No

Medications you have used in the past to control incontinence:

- ☐ Ditropan/Ditropan XL (oxybutynin)
- ☐ Tofranil
- ☐ Imipramine
- ☐ Urispas
- ☐ Sudafed (pseudoephedrine)
- ☐ Desmopressin (DDAVP)
- ☐ Detrol/Detrol LA (tolterodine)
- ☐ Enablex (darifenacin)
- ☐ VESIcare (solifenacin)
- ☐ Sancture (trospium)

FAMILY HISTORY

Please note if you have a family history of any of these diseases:

			Family Member
Breast cancer	☐ Yes	☐ No	
Ovarian cancer	☐ Yes	☐ No	
Other cancer: _____	☐ Yes	☐ No	
Heart disease	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Hypertension	☐ Yes	☐ No	
Other: _____			

DAILY ACTIVITIES

What kind of work do you do? _____

Who is your main support person (partner/spouse/friend)? _____

Do you consider yourself healthy? ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ No

- Starting at what age? _____
- Ending at what age? _____
- How many packs per day? _____

How many glasses of beer, wine, or other alcohol do you drink per day? _____

How many caffeinated beverages (coffee, tea, soda) do you drink per day? _____

Level of physical activity:

- ☐ Get regular aerobic exercise such as jogging and aerobics
- ☐ Able to do aerobic exercise but do not do it regularly
- ☐ Walk without assistance
- ☐ Require assistance to walk
- ☐ Use a wheelchair

Some women find that accidental urine loss and/or prolapse (falling or dropping of the uterus, vagina, bladder, or bowels) may affect their activities, relationships, and feelings. The questions below refer to areas in your life which may have been influenced or changed by your problem. For each question, check the response that best describes how much your activities, relationships, and feelings are being affected by urine leakage and/or prolapse.

Has urine leakage and/or prolapse affected your:

	Not at all	**Slightly**	**Moderately**	**Greatly**
Ability to do household chores?	☐	☐	☐	☐
Physical recreation such as walking, swimming, or other exercise?	☐	☐	☐	☐
Entertainment activities (movies, concerts, etc.)?	☐	☐	☐	☐
Ability to travel by car or bus more than 30 minutes from your home?	☐	☐	☐	☐
Participation in social activities outside your home?	☐	☐	☐	☐
Emotional health (nervousness, depression, etc.)?	☐	☐	☐	☐
Feeling frustrated?	☐	☐	☐	☐
Employment outside the home?	☐	☐	☐	☐

DAILY ACTIVITIES CONTINUED

The following symptoms have been described by women who experience accidental urine loss and/or prolapse. Please indicate which symptoms you are now experiencing, and how bothersome they are for you. Be sure to answer all questions by checking the appropriate space which best describes how you feel.

Do you experience, and if so, how much are you bothered by:

	Not at all	**Slightly**	**Moderately**	**Greatly**
Frequent urination?	☐	☐	☐	☐
Urine leakage related to the feeling of urgency?	☐	☐	☐	☐
Urine leakage related to physical activity, coughing, or sneezing?	☐	☐	☐	☐
Small amounts of urine leakage (drops)?	☐	☐	☐	☐
Difficulty emptying your bladder?	☐	☐	☐	☐
Pain or discomfort in the lower abdominal or genital area?	☐	☐	☐	☐
A feeling of bulging or protrusion in the vaginal area?	☐	☐	☐	☐
Bulging or protrusion you can see in the vaginal area?	☐	☐	☐	☐
Having to push on the vaginal walls with your fingers to have a bowel movement?	☐	☐	☐	☐