UROGYNECOLOGY PATIENT QUESTIONNAIRE

Date of Appointment: _____/____/_____  
Date of Birth: ________________

Patient Name ___________________________________  
Which physician are you seeing today:  
Dr. Carley  Dr. Boreham  Dr. Roshanravan  Dr. Kinman

Referring healthcare provider name/address: 
______________________________________________________________________________  
______________________________________________________________________________  
______________________________________________________________________________

Do you have a gynecologist who you have seen in the last 5 years? ____________________________
Gynecologist name and number: ___________________________________________________________________________

Primary care physician name and number: ______________________________________________________________________
Pharmacy phone number: ___________________________________________________________________________________

If you were referred by a healthcare provider, may we send correspondence regarding your visit and care?  
Yes  No

What bothers you most about your bladder or pelvic organs? (Please describe in your own words)  
______________________________________________________________________________  
______________________________________________________________________________  
______________________________________________________________________________  

How long have you had this? ________________
The problem is getting (Please circle one):  
worse  better  no change

Please list any other concerns regarding your bladder or pelvic organs you wish to discuss during your visit  
______________________________________________________________________________  
______________________________________________________________________________

1. Do you lose urine with any of the following activities: (Circle any that apply)

   a. Coughing  b. Walking  c. Lifting  
   d. Exercise  e. Sneezing  f. Laughing  
   g. Clearing your throat  h. Running  i. Standing up
   j. Orgasm  k. Pressure during intercourse  l. Washing your hands
   m. Seeing water  n. Putting the key in the door  o. Showering
   p. Cold weather  q. Other___________  r. Other___________

2. From the list above, during what 3 situations does your urine loss most bother you?

   ________________  ________________  ________________

3. How much does your urine loss bother you?  
(Please circle one)  
not-at-all  slightly  moderately  greatly

4. Do you ever lose urine while lying down? .................................................................Yes  No

5. Do you ever have a sudden urge to void and lose urine before you reach the toilet? ............Yes  No
   If so, how much does this bother you?  
(Please circle one)  
not-at-all  slightly  moderately  greatly

6. Circle the following word to best describe your urgency feeling when your bladder is full.  
(Please circle one)  
none  mild  moderate  severe

7. Do you ever leak urine suddenly without an urge while sitting quietly? ............................Yes  No
8. Do you experience complete bladder emptying for no apparent reason? ..........Yes No
9. Are you aware of the urine loss? .................................................Yes No
10. Did you have bedwetting problems beyond age 5? .........................Yes No
11. Do you wake up wet at night? ...............................................Yes No
12. Have you wet the bed in the past year? ....................................Yes No
13. Did your urine problem start after childbirth? ..........................Yes No
14. Did your urine problem start after an operation? .......................Yes No
15. Did your urine problem start after X-ray treatment? .................Yes No
16. Do you dribble urine when you stand up or cough after voiding. Yes No
17. Do fits of laughter cause complete emptying of your bladder?  Yes No
18. Do you lose urine in drops? ....................................................Yes No
19. Do you lose urine in large amounts? .......................................Yes No
20. Do you lose urine in spurts? ....................................................Yes No
21. Do you lose urine as a constant stream? .................................Yes No
22. How many times do you leak urine per day? _________________
23. If not daily, how many times do you leak urine per week? __________
24. Do you use a protective pad? .................................................Yes No
   If so, how many per day _____ per night _____
25. Have you modified any of the following activities because of urine loss: (Circle any that apply)
   Travel
   Social activities
   Physical recreation (exercise, walking, sports)
   Other ______________________
26. Do you feel it is bad enough to consider surgery? ........................Yes No
27. Do you have a strong desire to void often? .................................Yes No
28. Do you void often for fear of leaking? ....................................Yes No
29. Do you void often because of bladder pain or fear of pain? ........Yes No
30. Do you have pain during voiding? .........................................Yes No
   If so when does it occur? (Circle all that apply)
   Only at the end of voiding Only when an infection is found After voiding
31. Do you have pain as your bladder fills and decreased pain after voiding? Yes No
32. How many times do you void (urinate) during the day? ____________
33. How many times do you awaken from sleep to void? ______________
34. Does it take you a long time to start voiding? ............................Yes No
35. Do you assume different positions to help empty your bladder? ....Yes No
36. Do you strain to empty your bladder? .....................................Yes No
37. Do you put pressure on the lower abdomen to start urination? ....Yes No
38. Is your stream weak or prolonged? ........................................Yes No
39. Do you have a sensation of incomplete emptying after voiding? ...Yes No
40. Does the stream start and stop during urination? ......................Yes No
41. Do you feel vaginal or pelvic pressure? ....................................Yes No
42. Do you see or feel something protruding from the vagina? ..........Yes No
43. Have you used a pessary (device to hold up pelvic organs) in the past? Yes No
44. Do you press around the anus or in the vagina during bowel movements? Yes No
45. Do you lose control of intestinal gas (flatus)? ............................Yes No
46. Do you have fecal staining on your underwear? ........................Yes No
47. Do you have a strong desire to void often? .................................Yes No
48. Do you void often for fear of leaking? ....................................Yes No
49. Do you void often because of bladder pain or fear of pain? ........Yes No
50. Do you have pain during voiding? .........................................Yes No
47. Do you lose control of liquid stools? .................................................................Yes No
48. Do you lose control of formed stools? ..............................................................Yes No
49. Do you have problems with constipation? .......................................................Yes No
50. Do you have any blood in your stool? ..............................................................Yes No
51. Have you been treated for 3 or more bladder or kidney infections in your life? ....Yes No
52. Have you been treated for a bladder or kidney infection within the past year? ....Yes No
If yes, how many infections have you had within the past year? ____________
When was the last one? ____________
53. Do they occur one or 2 days after intercourse? ..............................................Yes No
54. Have the infections been diagnosed by urine cultures? ....................................Yes No
55. Is your urine ever bloody? ..............................................................................Yes No
If so, is it painful when you notice the bleeding? ______________
56. Have you ever passed gravel, sand, or stones in your urine? .........................Yes No
57. Have you ever been treated for kidney or bladder tumors? ............................Yes No
58. Are you sexually active? ................................................................................Yes No
If so, how often do you have intercourse? ______________
59. Do you have any discomfort with intercourse? ..............................................Yes No
60. Do you have any vaginal dryness with intercourse? ......................................Yes No
61. Are you or your partner having sexual difficulties or concerns? .................Yes No
62. Would you like treatment for any sexual concerns? ........................................Yes No
63. Do you smoke? Never No Yes If yes how many packs per day? ____________
64. How many 8 oz. glasses of water do you drink a day? ________________
65. How many 8 oz. glasses of other fluids do you drink a day? ________________
What types of fluids other than water do you normally drink in a day?
Coffee___oz., Tea___oz., Soda___oz., Alcoholic Beverages___oz, Fruit juices___oz
66. Have you had any prior treatment for urinary leakage? .................................Yes No
67. Have you had an operation for urinary leakage? ............................................Yes No
68. Have you ever taken medication for urinary leakage? .....................................Yes No
69. Please list any other treatments you have had for urinary leakage ____________

70. Do you have mitral valve prolapse? .................................................................Yes No
71. Do you have an artificial heart valve? ..............................................................Yes No
72. Do you have a joint (hip, knee, etc.) replacement? ........................................Yes No
73. Do you ever use antibiotics before any procedure for any reason? ..............Yes No
If yes, please list the reason(s) ______________________________________
74. Do you have any of the following medical conditions: (circle any that apply)
a. Diabetes Mellitus  b. Thyroid disease  c. Pernicious anemia
d. Paralysis  e. Stroke  f. Multiple Sclerosis
g. Parkinson’s Disease  h. Back or Brain surgery  i. Fibromyalgia
j. Blood clots in legs/lungs  k. Chronic cough  l. Smoking
m. Pacemaker  n. Heart failure  o. Weight problems
p. Glaucoma  q. Other r. Other
75. List any medications that you are currently taking (please include any vitamins or non-prescription medications). ________________________________
76. Please list all allergies and the reaction you have to them:

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Reaction Experienced</th>
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77. Please list any additional medical conditions for which you have received medical treatment in the past.

____________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________

78. Have you had any of the following operations/procedures? (If yes, please include the year and reason for each procedure)

<table>
<thead>
<tr>
<th>Surgery/Procedure</th>
<th>Year</th>
<th>Reason for the surgery/procedure</th>
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</thead>
<tbody>
<tr>
<td>Removal of the uterus</td>
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<tr>
<td>Removal of the ovaries</td>
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<tr>
<td>Bladder surgery</td>
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<tr>
<td>Brain/Back surgery</td>
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<td>Cystoscopy</td>
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<td>Urodynamic study</td>
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<tr>
<td>Urethral dilation</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

79. If you have had your uterus removed was it performed through the abdomen or vagina? ___________

80. If you have had bladder surgery was it performed through the abdomen or vagina? ______________

81. How many pregnancies have you had? ____________________

82. How many vaginal deliveries have you had? ____________________

83. How many Cesarean deliveries have you had? ____________________

84. Were forceps used for any of your deliveries? ____________________

85. Did you have an episiotomy for any of your deliveries? ____________________

86. What was the birth weight of your largest baby? ____________________

87. When was your last childbirth? ____________________

88. What is the date of your last menstrual period? ____________________

89. What type of contraception are you using? ____________________

90. What is the date of your last Pap smear? ____________________

91. What is the date of your last mammogram? ____________________

92. Are you menopausal? ................................................................. Yes  No
   If so, have you ever taken hormones? ........................................... Yes  No
   Are you currently taking hormones? ............................................. Yes  No

93. If you had previously taken hormones, but are not now, when did you stop taking them? ______________

94. If you had previously taken hormones, but are not now, why did you stop taking them? ____________________

95. Do any family members have a history of urine loss? ............................................ Yes  No
   If so, what relationship? _____________________________________________

96. Do any family members have a problem with vaginal prolapse or protrusion? .........................Yes  No
   If so, what relationship? _____________________________________________
ADDITIONAL REVIEW OF SYSTEMS: If you are currently having any problems in the following areas, please circle and explain.

**SKIN:** Itching, rash, infection, ulcer, tumors (growths), other  
None

**LYMPH NODES:** Swelling, tenderness, other  
None

**ENDOCRINE:** Fatigue, confusion, fainting, nervousness, hot/cold intolerance, hair loss  
other  
None

**BREASTS:** Tenderness, swelling lumps, discharge, other  
None

**RESPIRATORY:** Wheezing, cough (productive, blood), difficulty breathing, asthma, other  
None

**CARDIOVASCULAR:** Chest pain, swelling of extremities, shortness of breath, exercise  
intolerance, other  
None

**NERVOUS SYSTEM:** Loss of sensation in arms/legs, numbness or tingling, loss of  
consciousness, falls, difficulty walking, other  
None

**BLOOD/LYMPH:** Excessive bleeding, easy bruising, anemia, enlarged lymph nodes, other  
None

**ALLERGIES/IMMUNOLOGY:** Latex allergy, hay fever, other  
None

**PSYCHOLOGICAL:** Poor memory, difficulty concentration, anxiety, other  
None

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**Do you have a FAMILY HISTORY of the following? If so, whom?**

<table>
<thead>
<tr>
<th></th>
<th>Father’s Family</th>
<th>Mother’s Family</th>
<th>Siblings, Children, Nieces, Nephews</th>
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<tbody>
<tr>
<td>Breast Cancer:</td>
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<tr>
<td>Colon Cancer:</td>
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<td>Ovarian Cancer:</td>
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**Have any men in your family developed heart disease before age 55?**  
Y / N

**Have any women in your family developed heart disease before age 65?**  
Y / N

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*Thank you for taking the time to complete this questionnaire.*