Rutgers Robert Wood Johnson Medical Group
Female Pelvic Medicine & Reconstructive Surgery - Urogynecology
PATIENT MEDICAL HISTORY

Patient Name:_____ Date of birth: _____ Date:____/____/20___
Race: _____
Primary Care Physician: _____
Referring Physician: _____

FAMILY HISTORY

Mother: ☐ Living ☐ Deceased – Cause _____ Father: ☐Living ☐ Deceased – Cause _____
Sibling(s): Number living _____ Number deceased _____ Cause(s) _____
☐ Diabetes _____ ☐ Heart disease _____ ☐ High cholesterol _____
☐ Cancer _____ ☐ High blood pressure _____ ☐ Multiple sclerosis _____
Other _____

PAST HISTORY

Medical problems/Illnesses:

_____ _____ _____
_____ _____ _____
_____ _____

Medications – Current ☐ None

_____ _____
_____ _____
_____ _____

Allergies ☐ None

Surgeries:
(Please list the DATE / PROCEDURE / PLACE for each surgery below)

_____ _____
_____ _____
_____ _____

SOCIAL HISTORY

Tobacco use: ☐ No ☐ Yes
Alcohol/Drug use: ☐ No ☐ Yes
Domestic Violence: ☐ No ☐ Yes
Seat belt use: ☐ No ☐ Yes ☐ Diet discussed Regular exercise: ☐ No ☐ Yes

PAST GYNECOLOGIC HISTORY

Period – Age at onset _____ Length (days) _____ : ☐ Heavy ☐Light ☐ Cramps ☐ Clots
First Day of last period: _____
Age at menopause: _____
Are you sexually active: ☐ No ☐ Yes
Pain with intercourse: ☐ No ☐ Yes
Contraception: ☐ No ☐ Yes
Abnormal Pap smear: ☐ No ☐ Yes (treatment): _____

PAST OBSTETRIC HISTORY

Miscarriages: ☐ No ☐ Yes (number) _____
Deliveries:

	Date	Vaginal/Cesarean	Weight	Forceps/Vacuum	Episiotomy/laceration (Y/N)
1.					
2.					
3.					
4.					

REVIEW OF SYSTEMS

Do you have problems related to the following systems? Please mark the box ☐corresponding to No or Yes. Please *explain* any Yes answers in the space provided.

Constitutional Symptoms
- Fever ☐ No ☐ Yes
- Chills ☐ No ☐ Yes
- Headache ☐ No ☐ Yes
- Other _____

Eyes
- Blurred vision ☐ No ☐ Yes
- Double vision ☐ No ☐ Yes
- Pain ☐ No ☐ Yes
- Other _____

Allergic/Immunologic
- Hay fever ☐ No ☐ Yes
- Drug allergies ☐ No ☐ Yes
- Other _____

Neurological
- Tremors ☐ No ☐ Yes
- Dizzy spells ☐ No ☐ Yes
- Numbness/tingling ☐ No ☐ Yes
- Other _____

Endocrine
- Excessive thirst ☐ No ☐ Yes
- Diabetes ☐ No ☐ Yes
- Hypothyroid ☐ No ☐ Yes
- Other _____

Gastrointestinal
- Abdominal pain ☐ No ☐ Yes
- Nausea/vomiting ☐ No ☐ Yes
- Indigestion/heartburn ☐ No ☐ Yes
- Other _____

Cardiovascular
- Varicose veins ☐ No ☐ Yes
- Chest pain ☐ No ☐ Yes
- High blood pressure ☐ No ☐ Yes
- Other _____

Skin
- Skin rash ☐ No ☐ Yes
- Boils ☐ No ☐ Yes
- Persistent rash ☐ No ☐ Yes
- Other _____

Musculoskeletal
- Muscle weakness ☐ No ☐ Yes
- Joint pain ☐ No ☐ Yes
- Back pain ☐ No ☐ Yes
- Other _____

Ear/Nose/Throat/Mouth
- Headache ☐ No ☐ Yes
- Sinus problems ☐ No ☐ Yes
- Other _____

Genitourinary
- Urine retention ☐ No ☐ Yes
- Painful urination ☐ No ☐ Yes
- Urinary frequency ☐ No ☐ Yes
- Urinary urgency ☐ No ☐ Yes
- Urinary leakage ☐ No ☐ Yes
- Other _____

Respiratory
- Wheezing ☐ No ☐ Yes
- Frequent cough ☐ No ☐ Yes
- Shortness of breath ☐ No ☐ Yes
- Other _____

Hematologic/Lymphatic
- Swollen glands ☐ No ☐ Yes
- Bruises ☐ No ☐ Yes
- Other _____

Psychologic
- Depression ☐ No ☐ Yes
- Crying ☐ No ☐ Yes
- Other _____

Physician use only: (Comments/notes)

THE FOLLOWING STANDARDIZED QUESTIONNAIRES DIAGNOSE/SCREEN FOR PELVIC FLOOR DISORDERS AND MAY ADDRESS THE SAME CONDITION IN REPETITION.
PLEASE FILL THE QUESTIONNAIRES OUT ENTIRELY TO ENHANCE OUR CARE FOR WOMEN AFFECTED BY THESE SENSITIVE QUALITY-OF-LIFE DISORDERS.

1. How often do you experience urinary leakage?
   - ☐ Never
   - ☐ Less than once a month
   - ☐ A few times a month
   - ☐ A few times a week
   - ☐ Every day and/or night

2. How much urine do you lose each time?
   - ☐ Drops
   - ☐ Small splashes
   - ☐ More

INSTRUCTIONS: Following are a list of questions about you and your partner's sex life. All information is strictly confidential. Your confidential answers will be used only to help doctors understand what is important to patients about their sex lives. Please mark the box ☐ that best answers the question for you. While answering the questions, consider your sexuality over the past <u>six months</u>. Please mark only one box ☐ per question.

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

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

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

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

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

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

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

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

5. Do you feel pain during sexual intercourse?

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

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

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

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

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

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

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

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

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

10. Does your partner have a problem with <u>erections</u> that affects your sexual activity?

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

11. Does your partner have a problem with <u>premature ejaculation</u> that affects your sexual activity?

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

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

☐ Much less intense ☐ Less intense ☐ Same intensity ☐More intense ☐ Much more intense

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 <u>last 3 months.</u>

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

   If **yes**, how much does this bother you?
   ☐ **1** ☐ **2** ☐ **3** ☐ **4**
   Not at All - Somewhat - Moderately - Quite a bit

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

   If **yes**, how much does this bother you?
   ☐ **1** ☐ **2** ☐ **3** ☐ **4**
   Not at All - Somewhat - Moderately - Quite a bit

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

   If **yes**, how much does this bother you?
   ☐ **1** ☐ **2** ☐ **3** ☐ **4**
   Not at All - Somewhat - Moderately - Quite a bit

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

   If **yes**, how much does this bother you?
   ☐ **1** ☐ **2** ☐ **3** ☐ **4**
   Not at All - Somewhat - Moderately - Quite a bit

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

   If **yes**, how much does this bother you?

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

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**

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**

If **yes**, how much does this bother you?

☐ **1** ☐ **2** ☐ **3** ☐ **4**

Not at All - Somewhat - Moderately - Quite a bit

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

If **yes**, how much does this bother you?

☐ **1** ☐ **2** ☐ **3** ☐ **4**

Not at All - Somewhat - Moderately - Quite a bit

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

If **yes**, how much does this bother you?

☐ **1** ☐ **2** ☐ **3** ☐ **4**

Not at All - Somewhat - Moderately - Quite a bit

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

If **yes**, how much does this bother you?

☐ **1** ☐ **2** ☐ **3** ☐ **4**

Not at All - Somewhat - Moderately - Quite a bit

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

If **yes**, how much does this bother you?

☐ **1** ☐ **2** ☐ **3** ☐ **4**

Not at All - Somewhat - Moderately - Quite a bit

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

If **yes**, how much does this bother you?

☐ **1** ☐ **2** ☐ **3** ☐ **4**

Not at All - Somewhat - Moderately - Quite a bit

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

If **yes**, how much does this bother you?

☐ **1** ☐ **2** ☐ **3** ☐ **4**

Not at All - Somewhat - Moderately - 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**

If **yes**, how much does this bother you?
☐ **1** Not at All - ☐ **2** Somewhat - ☐ **3** Moderately - ☐ **4** Quite a bit

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

If **yes**, how much does this bother you?
☐ **1** Not at All - ☐ **2** Somewhat - ☐ **3** Moderately - ☐ **4** Quite a bit

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**

If **yes**, how much does this bother you?
☐ **1** Not at All - ☐ **2** Somewhat - ☐ **3** Moderately - ☐ **4** Quite a bit

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

If **yes**, how much does this bother you?
☐ **1** Not at All - ☐ **2** Somewhat - ☐ **3** Moderately - ☐ **4** Quite a bit

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

If **yes**, how much does this bother you?
☐ **1** Not at All - ☐ **2** Somewhat - ☐ **3** Moderately - ☐ **4** Quite a bit

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

If **yes**, how much does this bother you?
☐ **1** Not at All - ☐ **2** Somewhat - ☐ **3** Moderately - ☐ **4** Quite a bit

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

If **yes**, how much does this bother you?
☐ **1** Not at All - ☐ **2** Somewhat - ☐ **3** Moderately - ☐ **4** Quite a bit

INSTRUCTIONS: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feelings. For each question, place an 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.

How do symptoms or conditions relating to the following →→→→ Usually affect your ↓	Bladder or urine	Bowel or rectum	Vagina or pelvis
1. ability to do household chores (cooking, housecleaning, laundry)?	☐ 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?	☐ 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?	☐ 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 of greater than 30 minutes away from home?	☐ 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?	☐ 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, etc.)?	☐ 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?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

INSTRUCTIONS: For each of the following, please indicate on average in the past month if you experienced any amount of accidental bowel leakage: *(mark only one box per row).*

	2 or more times a DAY	Once a DAY	2 or more times a WEEK	Once a WEEK	1 to 3 Times A MONTH	Never
GAS						
MUCUS						
LIQUID STOOL						
SOLID STOOL						

INSTRUCTIONS: Please <u>mark</u> an "X" in the box for the answer that best describes how you feel for each question.

1. How many times do you go to the bathroom during the day?

☐3-6 ☐ 7-10 ☐11-14 ☐ 15-19 ☐20+

2a. How many times do you go to the bathroom at night?

☐0 ☐1 ☐ 2 ☐ 3 ☐ 4+

b. If you get up at night to go to the bathroom does it bother you?

☐Never ☐Mildly ☐Moderate ☐ Severe

3. Are you currently sexually active?

☐Yes ☐ No

4a. IF YOU ARE SEXUALLY ACTIVE, do you now or have you ever had pain or symptoms during or after sexual intercourse?

☐ Never ☐ Occasionally ☐ Usually ☐ Always

b. **If you have pain**, does it make you avoid sexual intercourse?

☐ Never ☐ Occasionally ☐ Usually ☐ Always

5. Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum)?

☐ Never ☐ Occasionally ☐ Usually ☐ Always

6. Do you have urgency after going to the bathroom?

☐ Never ☐ Occasionally ☐ Usually ☐ Always

7a. **If you have pain**, is it usually

☐ Mild ☐ Moderate ☐ Severe

b. Does your pain bother you?

☐ Never ☐ Occasionally ☐ Usually ☐ Always

8a. **If you have urgency**, is it usually

☐ Mild ☐ Moderate ☐ Severe

b. Does your urgency bother you?

☐ Never ☐ Occasionally ☐ Usually ☐ Always

Physician signature _____ Date: _____

☐ Juana Hutchinson-Colas, MD, MBA

☐ Saya Segal, MD, MSCE