THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER™
EDUCATION • RESEARCH • HEALTH CARE

Women's Specialty Care, Uro-Gynecology Division

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Name_____ **Date of Birth**_____ **Date** _____

Name of your Primary Care Physician:
Name of your OB/GYN Physician:
Name/Phone Number of your Preferred Pharmacy:

Reason for your visit:
List Allergies:

	Urinary Problems	**Stool Problems**	**Vaginal Problems**
Please check all problems that affect you	□ Constant urge to go to the bathroom □ I go to the bathroom every ___min ___hrs □ I wake up ___ times to go to the bathroom at night □ I leak with cough, laugh, sneeze □ I have burning with urination □ I have difficulty with urination or feel the bladder does not completely empty after going to the bathroom □ I lose urine while sleeping	□ I usually have constipation □ I usually have diarrhea □ I have stool accidents or leak stool with: □ Leakage of gas □ Leakage of liquid stool □ Leakage of solid stool	□ I have pelvic pressure □ I have pelvic pain □ I can feel a bulge through the vagina □ I can feel something is falling out through the vagina
How bad is your problem on a scale of 1-10	Rate (1=not bad, 10=very bad)	Rate (1=not bad, 10=very bad)	Rate (1=not bad, 10=very bad)
How long have you had this problem	# of years _____ # of months _____	# of years _____ # of months _____	# of years _____ # of months _____
Pad use, changing clothes	Type of pads _____ Number of pads /day _____ Number of clothing changes/day _____ Number of times leak/day _____	Number of pads /day _____ Number of clothing changes/day _____ Number of times leak/day _____	How often do you feel this: □ daily □ weekly □ monthly
Do you have	□ A strong urge to urinate when you hear the sound of running water	□ Leakage with certain foods □ Leakage with constipation □ Leakage with diarrhea	□ To use hands/fingers to urinate or have bowel movement

	□ Leakage with activity □ Leakage with intercourse		□ To change your position in the bathroom to urinate
Do you	□ Drink coffee or tea How many ounces daily? _____ □ Drink large amounts of fluid daily? How many ounces daily? ____	□ Have a history of a tear or episiotomy at childbirth □ Have anal intercourse	□ Have vaginal intercourse □ Is intercourse painful?
Please mark any treatments you had in the past	□ Medication □ Pessary □ Surgery	□ Medication □ Pessary □ Surgery	□ Medication □ Pessary □ Surgery

Current Medications: Please list any prescription and non-prescription drugs

_____
_____
_____
_____
_____

OB/GYN History: Please circle all that apply

Abnormal Pap
No cycles
Breast cancer
Cervical cancer
Chlamydia
Pre-cervical cancer
Pain with cycles
Pain with intercourse
Eclampsia
Endometrial polyp
Endometriosis
Fibroids
Genitals warts
Gestational diabetes
Gonorrhea
Herpes
HIV/AIDS
Hormone problems
Infertility
Heavy cycles
Osteoporosis
Ovarian Cancer
Polycystic ovarian syndrome
Pelvic inflammatory disease
Postpartum depression
Preeclampsia
RH negative
Syphilis
Urinary incontinence
Uterine cancer
Vaginal cancer
Vulvar cancer

Other: _____

Medical History: Please circle all that apply

Anemia
Anesthetic complications
Anxiety
Asthma
Blood dyscrasia
Blood transfusion
Breast problems
Clotting disorder
Coronary artery disease
Depression
Diabetes mellitus
Heart murmur
Hepatitis
Hypertension
Kidney disease
Liver disease
Lupus
Mental disorder
Osteoporosis
Seizures
Sickle Cell anemia
Drug abuse
Thyroid disease
Trauma/Violence
Urinary incontinence
Varicosities/Phlebitis

Other: _____

Surgical History: Please circle all that apply

Abdominal surgery	Cosmetic surgery	Left ovary removed
Appendectomy	D&C (dilate & curettage)	Pelvic laparoscopic surgery
Bladder suspension	Endometrial ablation	BTL (bilateral tubal ligation)
Breast enhancement	Cryosurgery	Right tube removed
Breast Surgery	Hysterectomy	Left tube removed
C-Section	Hysteroscopy	
Colon surgery	Laser conization	
Vaginal surgery	LEEP	
Colposcopy	Right ovary removed	

Other: _____

Family History: Please circle all that apply and list relative. Please note if it is a maternal -M (mother's side) or P-paternal (father's side) with disease

Breast cancer	Depression	Lupus
Colon cancer	Endometriosis	Mental illness
Ovarian cancer	Heart attack	Osteoporosis
Uterine cancer	Heart disease	Polycystic ovarian disease
Asthma	High Cholesterol	Thyroid disease
Diabetes	Hypertension	Prostate cancer

Other_____

Social History:

Alcohol use: Yes No
_____ glasses of wine per week
_____ cans of beer per week
_____shots of liquor per week

Sexually active: Yes No Not currently

Partners: male female both male and female

Birth Control/Protection**:** abstinence condoms diaphragm implant (nexplanon) injection IUD Birth control pill, contraceptive patch vaginal ring spermicide sponge
other_____

Drug use: Yes No if yes please list_____
Tobacco Use: never a smoker current every day smoker current some day smoker Former smoker
Smokeless tobacco: never used current user former user
Ready to quit tobacco products? Yes No

Occupation_____Employer_____

Marital status: single married separated divorced widowed

Years of education _____ Number of children_____

OB History:

# of Pregnancies ____ # of live births ____ # of miscarriages____ # of abortions____ # of living children____

	Delivery Date	Vaginal or C/S	Birth Weight	Weeks @ delivery	Male or female	Complications
1.						
2.						
3.						
4.						
5.						

Menstrual History:

Date of last period: _____
Age cycles started: _____
Period cycles (days) _____
Period durations (days) _____
Period pattern: regular irregular
Menstrual flow: light moderate heavy
Menstrual control: panty liner thin pad maxi pad hospital pad tampon other_____
Pain during cycles: none mild moderate severe

Preventative Health Maintenance History:

Date of last OB/GYN Visit_____ Provider's name_____
Date of last PCP visit: _____ Provider's name _____
Date of last Pap smear: _____ Location: _____
Date of last mammogram: _____ Location: _____
Date of last colonoscopy: _____ Location: _____
Date of last bone density: _____ Location: _____

Practices self-breast exams: Yes No
Regular exercise: Yes No
Healthy Diet: Yes No
Violence at home: Yes No
Depression: Yes No

CHECKLIST: Review of Systems

(Circle all that apply)

General-
Weight loss or gain
Fatigue
Fever or chills
Weakness
Trouble sleeping

Skin-
Rashes
Lumps
Itching
Dryness
Color changes
Hair and nail changes

Breasts-
Lumps
Pain
Discharge
Self-exams
Breast-feeding

Respiratory-
Cough
Sputum
Coughing up blood
Shortness of breath
Wheezing
Painful breathing

Cardiovascular-
Chest pain or discomfort
Tightness
Palpitations

Gastrointestinal-
Swallowing difficulties□
Heartburn
Change in appetite
Nausea
Change in bowel habits
Rectal bleeding
Constipation
Diarrhea
Yellow eyes or skin

Urinary-
Frequency
Urgency
Burning or pain
Blood in urine
Incontinence

Vascular-
Calf pain with walking
Leg cramping

Musculoskeletal-
Muscle or joint pain
Stiffness
Back pain
Redness of joints
Swelling of joints
Trauma

Neurologic-
Dizziness
Fainting
Seizures
Weakness
Numbness
Tingling
Tremor

Hematologic-
Easy bruising
Easy bleeding

Endocrine-
Hot or cold intolerance
Sweating
Frequent urination
Thirst
Change in appetite

Psychiatric-
Nervousness
Stress
Depression
Memory loss

INFORMATION FOR YOUR PHYSICIAN

Part 1

Instructions:
Please answer these questions by putting an **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 **past several months.** Thank you for your help.

1. **Do you usually experience pressure in the lower abdomen?**
   ☐ No; ☐ Yes
   If yes, how much does this bother you?
   ☐ 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?
   ☐ 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?
   ☐ 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?
   ☐ 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?
   ☐ 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?
   ☐ 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?
   ☐ 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?
   ☐ 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?

☐ 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?

☐ 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?

☐ 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?

☐ 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?

☐ 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?

☐ Not at All - ☐ Somewhat - ☐ Moderately - ☐ Quite a bit

15. Do you usually experience frequent urination?

☐ No; ☐ Yes

If yes, how much does this bother you?

☐ Not at All - ☐ Somewhat - ☐ Moderately - ☐ Quite a bit

16. Do you usually experience urine leakage associated with a feeling of urgency, that is a strong sense of needing to go to the bathroom?

☐ No; ☐ Yes

If yes, how much does this bother you?

☐ Not at All - ☐ Somewhat - ☐ Moderately - ☐ 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?

☐ Not at All - ☐ Somewhat - ☐ Moderately - ☐ 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?

☐ Not at All - ☐ Somewhat - ☐ Moderately - ☐ Quite a bit

19. Do you usually experience difficulty emptying your bladder?

☐ No; ☐ Yes

If yes, how much does this bother you?

☐ Not at All - ☐ Somewhat - ☐ Moderately - ☐ 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?

☐ Not at All - ☐ Somewhat - ☐ Moderately - ☐ Quite a bit

Part 2

Are you having sexual relations? [ ] yes [ ] no

*If you answered **yes**, we would appreciate it if you would fill out the questions below. If **no**, please go to **Part 3***

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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 check the box that best answers the question for you. While answering the question, consider your **sexuality in the last several months**. Thank you for your help

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.**
   [ ] Daily [ ] Weekly [ ] Monthly [ ] Less than once a month [ ] Never

2. **Do you climax (have an orgasm) when having sexual intercourse 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. **Are you satisfied 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 erections that affect your sexual activity?**
    [ ] Always [ ] Usually [ ] Sometimes [ ] Seldom [ ] Never

11. **Does your partner have a problem with premature ejaculation that affects your sexual activity?**
    [ ] Always [ ] Usually [ ] Sometimes [ ] Seldom [ ] Never

Part 3

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 **over the last several months**. Please be sure to mark an answer in **all 3 columns** for each question. Thank you

How do symptoms or conditions related 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 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