THE UNIVERSITY OF MISSISSIPPI
MEDICAL CENTER
EDUCATION • RESEARCH • HEALTHCARE

Women's Specialty Care, Urogynecology Division

Husam Abed, MD, and Paul Moore, MD

Locations

Mirror Lake – 2925 Layfair Drive, Flowood, MS 39232
Jackson Medical Mall – 350 Woodrow Wilson Drive, Jackson, MS 39213

Phone: 601-984-5314 Fax: 601-984-5477

Name_____________________________ MR#_______________ Date ________________

Name of your primary care physician: ____

Name of your OB/GYN physician:

Reason for your visit:

	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 activity □ Leakage with intercourse	□ Leakage with certain foods □ Leakage with constipation □ Leakage with diarrhea	□ To use hands/fingers to urinate or have bowel movement □ 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
Appendectomy
Bladder suspension
Breast enhancement
Breast Surgery
C-Section
Colon surgery
Vaginal surgery
Colposcopy
Cosmetic surgery
D&C (dilate & curettage)
Endometrial ablation
Cryosurgery
Hysterectomy
Hysteroscopy
Laser conization
LEEP
Right ovary removed
Left ovary removed
Pelvic laparoscopic surgery
BTL (bilateral tubal ligation)
Right tube removed
Left tube removed

Other: ____

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

Breast cancer
Colon cancer
Ovarian cancer
Uterine cancer
Asthma
Diabetes

Depression
Endometriosis
Heart attack
Heart disease
High Cholesterol
Hypertension

Lupus
Mental illness
Osteoporosis
Polycystic ovarian disease
Thyroid disease
Prostate cancer

Other:____

Social History: Please provide the following information about your health 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/s:	Vaginal or C-section delivery?	Birthweight/s:	Weeks at delivery?	Male or Female?	Complications?

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: ____

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

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-
- Head or cold intolerance
- Sweating
- Frequent urination
- Thirst
- Change in appetite

Psychiatric-
- Nervousness
- Stress
- Depression
- Memory loss

INFORMATION FOR YOUR PHYSICIAN

Part 1

Instructions:

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**.

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**.*

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, **please consider your sexuality over the last several months**.

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 mark an answer in all 3 columns for each question.

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