# Women's Specialty Care, Urogynecology Division

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## 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

<table>
<thead>
<tr>
<th>Name ______________________</th>
<th>MR# __________________</th>
<th>Date __________________</th>
</tr>
</thead>
</table>

Name of your primary care physician: ________________________________
Name of your OB/GYN physician: ________________________________

## Reason for your visit:

<table>
<thead>
<tr>
<th>Urinary Problems</th>
<th>Stool Problems</th>
<th>Vaginal Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please check all problems that affect you.</td>
<td>□ I usually have constipation</td>
<td>□ I have pelvic pressure</td>
</tr>
<tr>
<td>□ Constant urge to go to the bathroom</td>
<td>□ I usually have diarrhea</td>
<td>□ I have pelvic pain</td>
</tr>
<tr>
<td>□ I go to the bathroom every ___ min ___ hrs</td>
<td>□ I have stool accidents or leak stool with:</td>
<td>□ I can feel a bulge through the vagina</td>
</tr>
<tr>
<td>□ I wake up ___ times to go to the bathroom at night</td>
<td>□ Leakage of gas</td>
<td>□ I can feel something is falling out through the vagina</td>
</tr>
<tr>
<td>□ I leak with cough, laugh, sneeze</td>
<td>□ Leakage of liquid stool</td>
<td></td>
</tr>
<tr>
<td>□ I have burning with urination</td>
<td>□ Leakage of solid stool</td>
<td></td>
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<tr>
<td>□ I have difficulty with urination or feel the bladder does not completely empty after going to the bathroom</td>
<td></td>
<td></td>
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<tr>
<td>□ I lose urine while sleeping</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How bad is your problem on a scale of 1-10? Rate (1=not bad, 10=very bad)

<table>
<thead>
<tr>
<th>How long have you had this problem?</th>
<th>Rate (1=not bad, 10=very bad)</th>
<th>Rate (1=not bad, 10=very bad)</th>
</tr>
</thead>
<tbody>
<tr>
<td># of years ___</td>
<td># of months ___</td>
<td># of years ___</td>
</tr>
</tbody>
</table>

Pad use, changing clothes:

<table>
<thead>
<tr>
<th>Type of pads</th>
<th>Number of pads /day</th>
<th>Number of clothing changes/day</th>
<th>Number of times leak/day</th>
<th>How often do you feel this:</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>□ daily</td>
</tr>
<tr>
<td>Number of times leak/day</td>
<td></td>
<td></td>
<td></td>
<td>□ weekly</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ monthly</td>
</tr>
</tbody>
</table>

Do you have:

| □ A strong urge to urinate when you hear the sound of running water | □ Leakage with certain foods | □ To use hands/fingers to urinate or have bowel movement |
| □ Leakage with activity | □ Leakage with constipation | □ To change your position in the bathroom to urinate |
| □ Leakage with intercourse | □ Leakage with diarrhea | |

Do you:

| □ Drink coffee or tea | □ Have a history of a tear or episiotomy at childbirth | □ Have vaginal intercourse |
| □ How many ounces daily? | □ Have anal intercourse | □ Is intercourse painful? |
| _____ | | |
| □ Drink large amounts of fluid daily? | | |
| How many ounces daily? _____ | | |

Please mark any treatments you had in the past.

| □ Medication | □ Medication | □ Medication |
| □ Pessary | □ Pessary | □ Pessary |
| □ Surgery | □ Surgery | □ 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
Hysterotomy
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.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Disease</th>
<th>Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer</td>
<td>Depression</td>
<td>Lupus</td>
</tr>
<tr>
<td>Colon cancer</td>
<td>Endometriosis</td>
<td>Mental illness</td>
</tr>
<tr>
<td>Ovarian cancer</td>
<td>Heart attack</td>
<td>Osteoporosis</td>
</tr>
<tr>
<td>Uterine cancer</td>
<td>Heart disease</td>
<td>Polycystic ovarian disease</td>
</tr>
<tr>
<td>Asthma</td>
<td>High Cholesterol</td>
<td>Thyroid disease</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Hypertension</td>
<td>Prostate cancer</td>
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<tr>
<td>Other:</td>
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</table>

**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:

<table>
<thead>
<tr>
<th># of pregnancies: ___</th>
<th># of live births: ___</th>
<th># of miscarriages: ___</th>
<th># of abortions: ___</th>
<th># of living children: ___</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Delivery date/s:</th>
<th>Vaginal or C-section delivery?</th>
<th>Birthweight/s:</th>
<th>Weeks at delivery?</th>
<th>Male or Female?</th>
<th>Complications?</th>
</tr>
</thead>
<tbody>
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</table>

### 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:

<table>
<thead>
<tr>
<th>Date of last OB/GYN visit: __________</th>
<th>Provider’s name: ______________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of last PCP visit: __________</td>
<td>Provider’s name: ______________________</td>
</tr>
<tr>
<td>Date of last pap smear: __________</td>
<td>Location: _____________________________</td>
</tr>
<tr>
<td>Date of last mammogram: __________</td>
<td>Location: _____________________________</td>
</tr>
<tr>
<td>Date of last colonoscopy: __________</td>
<td>Location: _____________________________</td>
</tr>
<tr>
<td>Date of last bone density: __________</td>
<td>Location: _____________________________</td>
</tr>
</tbody>
</table>

- 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

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

Neurologic-
Dizziness
Fainting
Seizures
Weakness
Numbness
Tingling
Tremor

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

Vascular-
Calf pain with walking
Leg cramping

Urinary-
Frequency
Urgency
Burning or pain
Blood in urine
Incontinence

Hematologic-
Easy bruising
Easy bleeding

Psychiatric-
Nervousness
Stress
Depression
Memory loss
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.

<table>
<thead>
<tr>
<th>How do symptoms or conditions related to the following usually affect your…</th>
<th>Bladder or urine</th>
<th>Bowel or rectum</th>
<th>Vagina or pelvis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ability to do household chores (cooking, housecleaning, laundry)?</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
</tr>
<tr>
<td>2. Ability to do physical activities such as walking, swimming, or other exercise?</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
</tr>
<tr>
<td>3. Entertainment activities such as going to a movie or concert?</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
</tr>
<tr>
<td>4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
</tr>
<tr>
<td>5. Participating in social activities outside your home?</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
</tr>
<tr>
<td>6. Emotional health (nervousness, depression, etc.)?</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
</tr>
<tr>
<td>7. Feeling frustrated?</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
<td>□ Not at all □ Somewhat □ Moderately □ Quite a bit</td>
</tr>
</tbody>
</table>