Patient ID will go here.

Welcome!

New Patient Initial Medical and Surgical History and Symptom Inventory

PATIENT IDENTIFICATION

Last Name ____________ First Name ____________

Date of Birth (mm/dd/yyyy) ___/___/_____ Today's Date (mm/dd/yyyy) ___/___/_____

YOUR PHYSICIANS

In order for us to communicate with your personal physicians with our assessment and recommendations, please list your physician(s) below.

Name of Primary Care Physician	**Name of Physician who Recommended this Consult** ☐ Check here if same as PCP
Address	Address
City / State / ZIP Code	City / State / ZIP Code
Doctor's Phone Number	Doctor's Phone Number

PAST MEDICAL HISTORY

Please indicate whether (to your knowledge) you have any of these conditions:

Condition	Yes	No
Low blood count (anemia)	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Osteoarthritis	☐ Yes	☐ No
Rheumatoid arthritis	☐ Yes	☐ No
Lupus	☐ Yes	☐ No
Sjogrens	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Peripheral vascular disease (claudication)	☐ Yes	☐ No
Heart disease (angina) heart attack	☐ Yes	☐ No
Congestive heart failure	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Abnormal heart rate	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Diabetes mellitus	☐ Yes	☐ No
Indigestion	☐ Yes	☐ No
Ulcer (stomach or intestinal)	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Liver disease	☐ Yes	☐ No
Liver failure	☐ Yes	☐ No
Kidney failure	☐ Yes	☐ No
Kidney stones	☐ Yes	☐ No
Migraine headaches	☐ Yes	☐ No
Cancer		
Breast	☐ Yes	☐ No
Colon	☐ Yes	☐ No
Uterus	☐ Yes	☐ No
Ovary	☐ Yes	☐ No
Leukemia or lymphoma	☐ Yes	☐ No
Other cancer ________________	☐ Yes	☐ No
Alzheimer's Dementia	☐ Yes	☐ No
Parkinson's disease	☐ Yes	☐ No
Multiple sclerosis	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No
HIV or AIDS	☐ Yes	☐ No

Other condition(s) (please list)________________

PAST GYNECOLOGIC HISTORY

Please describe your gynecological history by answering the questions below:

Are you still having your period (menstruating)? ☐ Yes ☐ No

If no, at what age did you stop? ________________

If you are still having your period:

How often do you have your period (menses)? (please pick one)

- ☐ Regularly (about once per month)
- ☐ Too frequently
- ☐ Infrequently

Is your flow? (please pick one)

- ☐ Normal
- ☐ Light
- ☐ Heavy

Do you have severe menstrual cramps? ☐ Yes ☐ No

Are you taking estrogen replacement therapy? ☐ Yes ☐ No

If yes, what type? ________________________

Have you had any of the following gynecologic surgeries?

- Dilation and curettage ☐ Yes ☐ No
- Hysteroscopy (look into uterus with camera) ☐ Yes ☐ No
- Tie tubes ☐ Yes ☐ No
- Hysterectomy ☐ Yes ☐ No
  - If yes, please pick one:
    - ☐ Abdominal hysterectomy
    - ☐ Vaginal hysterectomy
    - ☐ Laparoscopic hysterectomy
    - ☐ Not sure

Have you had surgery on an ovary (e.g., remove cyst)? ☐ Yes ☐ No

- Remove one ovary ☐ Yes ☐ No
- Remove both ovaries ☐ Yes ☐ No

Have you had surgery for uterine or vaginal prolapse? ☐ Yes ☐ No

If yes: Type of surgery ____________________

Year performed ____________________

Have you had surgery for bladder control? ☐ Yes ☐ No

If yes: Type of surgery ____________________

Year performed ____________________

OTHER PAST SURGICAL HISTORY

Please check "yes" or "no" for each surgery listed:

- Appendectomy ☐ Yes ☐ No
- Breast surgery (biopsy, lumpectomy, or mastectomy) ☐ Yes ☐ No
- Breast plastic surgery ☐ Yes ☐ No
- Spine surgery ☐ Yes ☐ No
- Abdominal plastic surgery (e.g., "tummy tuck") ☐ Yes ☐ No
- Cholecystectomy (remove gallbladder) ☐ Yes ☐ No
- Hernia repair ☐ Yes ☐ No
- Diagnostic Laparoscopy (look into abdomen with camera) ☐ Yes ☐ No
- Hip surgery ☐ Yes ☐ No
- Knee surgery ☐ Yes ☐ No
- Tonsilectomy ☐ Yes ☐ No
- Thyroid surgery ☐ Yes ☐ No

Other surgery (please list) ____________________

____

____

PAST OBSTETRICAL HISTORY

TOTAL number of ***pregnancies*** _____

Number of ectopic (tubal) pregnancies _____

Number of miscarriages _____

Number of abortions _____

Number of cesarean deliveries _____

Number of vaginal deliveries _____

Of these vaginal deliveries, how many involved forceps or vacuum _____

What was the weight of your largest child delivered vaginally (in pounds)? _____

Have you had at least one episiotomy or vaginal tear? ☐ Yes ☐ No ☐ Unknown

Have you had at least one tear into rectum? ☐ Yes ☐ No ☐ Unknown

FAMILY HISTORY

Does anyone in your family have any of the following?

High blood pressure ☐ Yes ☐ No

Heart disease (angina) or heart attack ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Diabetes mellitus ☐ Yes ☐ No

Cancer

- Breast ☐ Yes ☐ No
- Colon ☐ Yes ☐ No
- Uterine ☐ Yes ☐ No
- Ovarian ☐ Yes ☐ No

RACE AND ETHNICITY

Do you consider your ethnicity to be Hispanic or Latino? ☐ Yes ☐ No

Do you consider yourself to be (select all that apply):

☐ White/Caucasian
☐ Black/African American
☐ Asian
☐ Native Hawaiian/Pacific Islander
☐ American Indian/Alaskan Native
☐ Other
☐ Decline to answer

If more than one race was selected, which do you consider to be your primary racial background? (please select one)

☐ White/Caucasian
☐ Black/African American
☐ Asian
☐ Native Hawaiian/Pacific Islander
☐ American Indian/Alaskan Native
☐ Other
☐ Decline to answer

EDUCATION

Please indicate your highest level of education (please pick one)

☐ Elementary school
☐ Junior high school
☐ High school
☐ College degree
☐ Graduate degree
☐ Decline to answer

SOCIAL HISTORY

Are you married? ☐ Yes ☐ No Are you currently sexually active with a partner? ☐ Yes ☐ No

Please describe your tobacco use (please pick one)

☐ Never ☐ Past ☐ Present

If you have smoked cigarettes please list: Number of packs/day_____ Years smoking_____

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how many alcoholic drinks per week?_____

ALLERGIES

Do you have any allergies to medicines? ☐ Yes ☐ No

If yes, please list the medications and describe the allergic reaction:

Medication	What Kind of Reaction?	Allergy	What Kind of Reaction?

REVIEW OF SYMPTOMS

Please check all symptoms that apply to you:

Symptom		
Fatigue (tiredness)	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No
Weight gain	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Breast mass	☐ Yes	☐ No
Breast discharge	☐ Yes	☐ No
Hearing problems	☐ Yes	☐ No
Can't lie flat without getting short of breath	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
Passing out (fainting)	☐ Yes	☐ No
Abnormal bleeding tendency	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Nausea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Loss of appetite	☐ Yes	☐ No
Bleeding from rectum	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Joint pain	☐ Yes	☐ No
Leg swelling	☐ Yes	☐ No
Frequent headache	☐ Yes	☐ No
Difficulty seeing	☐ Yes	☐ No
Difficulty talking	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Weakness in any specific part of your body	☐ Yes	☐ No
Numbness in any specific part of your body	☐ Yes	☐ No
Pins and needles sensations	☐ Yes	☐ No

BLADDER & BOWEL DYSFUNCTION

On average, how many times do you:

- urinate during waking hours? _____
- get up from sleeping to urinate? _____

On average, how many bowel movements do you have per week? _____

Do you use pads for any of the following reasons besides menstrual flow?

- Urinary incontinence ☐ Yes ☐ No
- Fecal incontinence ☐ Yes ☐ No
- Other ☐ Yes ☐ No

If you use pads for incontinence, what type of pads do you use? (please pick one)

- ☐ None
- ☐ Minipad
- ☐ Shield
- ☐ Diaper

If you use pads for incontinence, how many per 24 hours?

Number of pads per day _____

PELVIC FLOOR DISTRESS INVENTORY - SHORT FORM 20 (PFDI-20)

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 **last 3 months.**

1. Do you usually experience *pressure* in the lower abdomen?

☐ 0 No ☐ Yes If yes, how much does this bother you? ☐ 1 Not at All ☐ 2 Somewhat ☐ 3 Moderately ☐ 4 Quite a bit

2. Do you usually experience *heaviness or dullness* in the pelvic area?

☐ 0 No ☐ Yes If yes, how much does this bother you? ☐ 1 Not at All ☐ 2 Somewhat ☐ 3 Moderately ☐ 4 Quite a bit

3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?

☐ 0 No ☐ Yes If yes, how much does this bother you? ☐ 1 Not at All ☐ 2 Somewhat ☐ 3 Moderately ☐ 4 Quite a bit

4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?

☐ 0 No ☐ Yes If yes, how much does this bother you? ☐ 1 Not at All ☐ 2 Somewhat ☐ 3 Moderately ☐ 4 Quite a bit

5. Do you usually experience a feeling of incomplete bladder emptying?

☐ 0 No ☐ Yes If yes, how much does this bother you? ☐ 1 Not at All ☐ 2 Somewhat ☐ 3 Moderately ☐ 4 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?

☐ 0 No ☐ Yes If yes, how much does this bother you? ☐ 1 Not at All ☐ 2 Somewhat ☐ 3 Moderately ☐ 4 Quite a bit

7. Do you feel you need to strain too hard to have a bowel movement?

☐ 0 No ☐ Yes If yes, how much does this bother you? ☐ 1 Not at All ☐ 2 Somewhat ☐ 3 Moderately ☐ 4 Quite a bit

8. Do you feel you have not completely emptied your bowels at the end of a bowel movement?

☐ 0 No ☐ Yes If yes, how much does this bother you? ☐ 1 Not at All ☐ 2 Somewhat ☐ 3 Moderately ☐ 4 Quite a bit

9. Do you usually lose stool beyond your control if your stool is well formed?

☐ 0 No ☐ Yes If yes, how much does this bother you? ☐ 1 Not at All ☐ 2 Somewhat ☐ 3 Moderately ☐ 4 Quite a bit

10. Do you usually lose stool beyond your control if your stool is loose or liquid?

☐ 0 No ☐ Yes If yes, how much does this bother you? ☐ 1 Not at All ☐ 2 Somewhat ☐ 3 Moderately ☐ 4 Quite a bit

11. Do you usually lose gas from the rectum beyond your control?

☐ 0 No ☐ Yes — If yes, how much does this bother you? ☐ 1 Not at All ☐ 2 Somewhat ☐ 3 Moderately ☐ 4 Quite a bit

12. Do you usually have pain when you pass your stool?

☐ 0 No ☐ Yes — If yes, how much does this bother you? ☐ 1 Not at All ☐ 2 Somewhat ☐ 3 Moderately ☐ 4 Quite a bit

13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?

☐ 0 No ☐ Yes — If other than never, how much does this bother you? ☐ 1 Not at All ☐ 2 Somewhat ☐ 3 Moderately ☐ 4 Quite a bit

14. Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?

☐ 0 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?

☐ 0 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?

☐ 0 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?

☐ 0 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)?

☐ 0 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?

☐ 0 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?

☐ 0 No ☐ Yes — If yes, how much does this bother you? ☐ 1 Not at All ☐ 2 Somewhat ☐ 3 Moderately ☐ 4 Quite a bit

PELVIC FLOOR IMPACT QUESTIONNAIRE – SHORT FORM 7 (PFIQ 7)

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. Thank you for your cooperation.

How do symptoms or conditions related to the following usually affect your:

1. Ability to do household chores (cooking, housecleaning, laundry)?

Bladder or Urine		Bowel or Rectum		Vagina or Pelvis	
☐ Not at all	☐ Moderately	☐ Not at all	☐ Moderately	☐ Not at all	☐ Moderately
☐ Somewhat	☐ Quite a bit	☐ Somewhat	☐ Quite a bit	☐ Somewhat	☐ Quite a bit

2. Ability to do physical activities such as walking, swimming or other exercise?

Bladder or Urine		Bowel or Rectum		Vagina or Pelvis	
☐ Not at all	☐ Moderately	☐ Not at all	☐ Moderately	☐ Not at all	☐ Moderately
☐ Somewhat	☐ Quite a bit	☐ Somewhat	☐ Quite a bit	☐ Somewhat	☐ Quite a bit

3. Entertainment activities such as going to a movie or concert?

Bladder or Urine		Bowel or Rectum		Vagina or Pelvis	
☐ Not at all	☐ Moderately	☐ Not at all	☐ Moderately	☐ Not at all	☐ Moderately
☐ Somewhat	☐ Quite a bit	☐ Somewhat	☐ Quite a bit	☐ Somewhat	☐ Quite a bit

4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?

Bladder or Urine		Bowel or Rectum		Vagina or Pelvis	
☐ Not at all	☐ Moderately	☐ Not at all	☐ Moderately	☐ Not at all	☐ Moderately
☐ Somewhat	☐ Quite a bit	☐ Somewhat	☐ Quite a bit	☐ Somewhat	☐ Quite a bit

5. Participating in social activities outside your home?

Bladder or Urine		Bowel or Rectum		Vagina or Pelvis	
☐ Not at all	☐ Moderately	☐ Not at all	☐ Moderately	☐ Not at all	☐ Moderately
☐ Somewhat	☐ Quite a bit	☐ Somewhat	☐ Quite a bit	☐ Somewhat	☐ Quite a bit

6. Emotional health (nervousness, depression)?

Bladder or Urine		Bowel or Rectum		Vagina or Pelvis	
☐ Not at all	☐ Moderately	☐ Not at all	☐ Moderately	☐ Not at all	☐ Moderately
☐ Somewhat	☐ Quite a bit	☐ Somewhat	☐ Quite a bit	☐ Somewhat	☐ Quite a bit

7. Feeling frustrated?

Bladder or Urine		Bowel or Rectum		Vagina or Pelvis	
☐ Not at all	☐ Moderately	☐ Not at all	☐ Moderately	☐ Not at all	☐ Moderately
☐ Somewhat	☐ Quite a bit	☐ Somewhat	☐ Quite a bit	☐ Somewhat	☐ Quite a bit

PELVIC ORGAN PROLAPSE/URINARY INCONTINENCE SEXUAL FUNCTION QUESTIONNAIRE

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

☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
Daily	Weekly	Monthly	Less than once a month	Never

2. (PISQ 2) Do you climax (have an orgasm) when having *sexual intercourse* with your partner?

☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
Always	Usually	Sometimes	Seldom	Never

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

☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
Always	Usually	Sometimes	Seldom	Never

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

☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
Always	Usually	Sometimes	Seldom	Never

5. (PISQ 5) Do you feel pain during sexual intercourse?

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Always	Usually	Sometimes	Seldom	Never

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

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Always	Usually	Sometimes	Seldom	Never

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

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Always	Usually	Sometimes	Seldom	Never

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

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Always	Usually	Sometimes	Seldom	Never

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

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Always	Usually	Sometimes	Seldom	Never

10. (PISQ 10) Does your partner have a problem with *erections* that affects your sexual activity?

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Always	Usually	Sometimes	Seldom	Never

11. (PISQ 11) Does your partner have a problem with premature *ejaculation* that affects your sexual activity?

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Always	Usually	Sometimes	Seldom	Never

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

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Much less intense	Less intense	Same intensity	More intense	Much more intense