Texas Health Care

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LAST NAME: ______________________ FIRST NAME: _____________ AGE: ________

Date of Appointment: ________________ Date of Birth: ____________ Race:_________

Referring Physician: __________________ Other Referral: ______________________________

Chief Complaint (why you came to see the doctor today): _________________________________
____
____

PELVIC ORGAN SYMPTOMS:

BLADDER CONTROL PROBLEMS:

Do you have problems with accidental loss of urine or urinary urgency/frequency? Yes No

IF YOU ANSWERED YES CONTINUE IF NO SKIP TO NEXT SECTION

How many months or years have you had bladder problems? ________Months _________ Years

Do you use pads to absorb lost urine? Yes No If yes, how many pads do you wear in a day? _______

About how many trips do you make to the bathroom during the day? __________

About how many times do you wake at night to go to the bathroom? __________

Do you ever wet the bed while asleep? Yes No

Are there times when you cannot make it to the bathroom in time? Yes No

Does the sound, sight or feel of running water cause you to lose urine? Yes No

Which best describes urine loss: *check all that apply*

_____ I lose urine during coughing, sneezing, running or lifting

_____ I lose urine with changes in posture, standing or walking

_____ I lose urine continuously such that I am constantly wet

_____ I have sudden,urgent needs without the ability to make it to the bathroom

Have you seen a physician for complaints of urine loss? Yes No If yes, who ____________________

Have you taken medication to prevent urine loss? Yes No If yes, what medication ___________________

How many glasses of liquid do you consume daily? ______________________

How many drinks containing caffeine (coffee, tea, soda) do you consume daily? _______________

BLADDER EMPTYING PROBLEMS:

Do you have problems with urinating or emptying your bladder completely? Yes No

IF YOU ANSWERED YES CONTINUE, IF NO SKIP TO NEXT SECTION

How long have you had bladder emptying problems? ________Months _________ Years

Do you notice any dribbling of urine when you stand after passing urine? Yes No

Do you usually have difficulty starting your urine stream? Yes No

Do you have to assume abnormal positions to urinate? Yes No

Do you have to strain to empty your bladder? Yes No

Is your urine flow: Strong Weak Dribbling Intermittent

Do you feel as if your bladder is empty after passing urine? Yes No

PROLAPSE/VAGINAL SUPPORT PROBLEMS:

Do you have a feeling of fullness or pressure, bulge or protrusion of any vaginal tissue? Yes No

IF YOU ANSWERED YES CONTINUE, IF NO SKIP TO NEXT SECTION

Do you notice a bulge? Yes No

How long have you had a protrusion or bulge? ________Months _________ Years

Are your symptoms worse at the end of the day or after standing for prolonged periods? Yes No

Do you push the protrusion back to help with a bowel movement or to empty your bladder? Yes No

Have you ever used a pessary (a plastic support device) for this problem? Yes No

BOWEL SYMPTOMS:

Do you have problems with your bowels (bowel incontinence or difficulty emptying your bowels)? Yes No

IF YOU ANSWERED YES CONTINUE, IF NO SKIP TO NEXT SECTION

How long have you had bowel symptoms? ________Months _________ Years

Do you have accidental loss of solid stool? Yes No

Do you have accidental loss of liquid stool? Yes No

Do you have accidental loss of gas? Yes No

How long have you had accidental loss or stool or gas? ________Months _________ Years

How many episodes per week? _______________

Do you wear protective pads for this problem? Yes No If yes, how many pads a day ___________

Do you have constipation? Yes No Diarrhea? Yes No Bloating? Yes No

Do you have a frequent desire to have a bowel movement? Yes No

Do you feel that your bowels are never completely empty? Yes No

Do you ever place your fingers in your vagina between the vagina and rectum to help with a bowel movement?
Yes No

Have you seen a physician for bowel symptoms? Yes No If yes, who ______________________________

SEXUAL HISTORY:

Are you sexually active? Yes No

If not sexually active, are barriers to sexual activity due to:

Prolapse (vaginal bulging) Yes No

Incontinence Yes No

Pain Yes No

PELVIC PAIN:

Do you have pain in your pelvic area? Yes No

IF YOU ANSWERED YES CONTINUE, IF NO SKIP TO NEXT SECTION

Where is your pain? ____Pelvic Area ____Vagina ____Rectum ____Lower Abdomen

How long have you had pelvic pain? ________Months _________ Years

Is your pain relieved by bladder emptying? Yes No

Do you have pain with urination? Yes No

Does anything relieve the pain? Yes No If yes, what ______________________________

Do you see a pain specialist? Yes No If yes, who ______________________________

GYN HISTORY:

Of Pregnancies ___________ # of Deliveries __________ # of Miscarriages__________

Pregnancy	Delivered Y/N	Miscarriage or Abortion Y/N	Route of Delivery (Vag/C-Section)	Weight	Living (Y/N)

MEDICAL HISTORY: (check all that apply)

___Abnormal Pap
___Anesthetic Complications
___Asthma
___Auto Immune Disorder
___Breast Cancer
___Cancer
___Depression
___Diabetes
___Endometrial Cancer
___Heart Disease
___Hepatitis
___Hypertension
___Kidney Disease
___Mental/Physical Abuse
___Postpartum Depression
___ Psychiatric Disorder
___Seizures
___Sexual Abuse
___Sexual Dysfunction
___Thyroid Disease
___Uterine Abnormality

If Heart Problems, please specify: ______________________________

Cardiologist Name: ______________________________

If Cancer, please specify: ______________________________

Other: ______________________________

Do you see any other specialist, if so, please provide name and speciality: ______________________________

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SURGICAL HISTORY:

Hysterectomy Date: ______________ Reason: ___Prolapse ___Fibroids ___Bleeding ___Endometriosis
Incision: ___Vaginal ___Abdominal ___Laparoscopic Assisted

Bladder Repair Date:_______________ Reason: ___Prolapse ___Leakage
Incision: ___Vaginal ___Abdominal

___Breast Surgery ___C-section ___Vulvar Surgery ___Hysteroscopy
___Cryosurgery ___Myomectomy ___Endometrial Ablation ___Vaginal Surgery
___Tubal Ligation ___Laparascopy/Laparotomy ___D&C

List any other surgeries below with dates:

_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________

Drug Allergies:

___No Known Drug Allergies

Name: Reaction Name Reaction

____ ____
____ ____
____ ____

CURRENT PRESCRIPTION MEDICATIONS:

NAME: DOSE: PURPOSE/INDICATION:

____
____
____
____
____
____
____
____
____
____

SOCIAL HISTORY:

Marital Status	___Single	___Married	___Divorced	___Widowed	___Seperated
Alcohol Use	___Never	___Rarely	___Occasionally ___Daily		
Tobacco Use	___Never	___Current___Packs per day for ___years			
	___Quit *If so when?*______How long did you smoke______				
Drug Use	___Never	___Recreational	___Daily		
	_________________Type				

Occupation: ____

Does your occupation require heavy lifting? (<25lbs) Yes No

FAMILY HISTORY: *Check all that apply and indicate relationship of relative*

___Cancer (*specify site*)_________________________

___Heart Disease_________________________

___Hypertension_________________________

___Reactions to Anesthesia___________________

___Bleeding Disorder_________________________

___Diabetes_________________________

___Stroke_________________________

___Other_________________________

REVIEW OF SYMPTOMS: *(circle all that apply)*

Fever	Blurred Vision	Heartburn	Easily bruises/bleed
Chills	Double Vision	Nausea	Environmental Allergies
Weight Loss	Light Sensitivity	Vomiting	Excessive Thirst
Fatigue	Eye Pain	Abdominal Pain	Dizziness
Sweating	Eye Discharge	Diarrhea	Tingling
Weakness	Eye Redness	Constipation	Tremors
Rash	Chest Pain	Blood in Stool	Sensory Change
Itching	Palpitations	Urgency	Speech Change
Headaches	Difficulty Breathing	Frequency	Seizures
Hearing Loss	Leg Pain	Blood in Urine	Loss of Consciousness
Ringing of Ears	Leg Swelling	Flank Pain	Depression
Ear Pain	Cough	Muscle Pain	Suicidal Thoughts
Ear Discharge	Coughing up Blood	Neck Pain	Substance Abuse
Nosebleeds	Productive Cough	Back Pain	Hallucinations
Congestions	Shortness of breath	Joint Pain	Anxiety
Noisy Breathing	Wheezing	Falls	Insomnia
Sore Throat			Memory Loss

Other Symptoms:

____

____

____ ______________________

Patient or Guardian's Signature Date

Name:_____________________________________Date of Birth:__________________Date:____________

This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual daily activities. Answer every questions by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

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1. In general, could you say your health is: ___Excellent ___Very Good____Good____Fair____Poor

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The following questions are about activities you might do during a typical day. Does your health **now** limit you in these activities? If so, how much?

2. Moderate activities such as moving a table, pushing a vacuum cleaner, bowling or playing golf?

_____Limited a lot _____Limited a little _____No limits at all

3. Climbing several flights of stairs

_____Limited a lot _____Limited a little _____No limits at all

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During the past **4 weeks** have you had any of the following problems with your work or regular daily activities as a result of your physical health?

4. Accomplished less than you would like Yes No

5. Were limited in the kind of work or other activities Yes No

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During the past **4 weeks** have you had any of the following problems with your work or regular daily activities as a result of any emotional problems? (such as feeling depressed or anxious)

6. Accomplished less than you would like Yes No

7. Didn't do work or other activities as carefully as usual Yes No

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During the past **4 weeks**, how much did pain interfere with your normal work (including both work outside the home and or housework)

_____Not at all _____Limited a little _____Moderately _____Quite a bit _____Extremely

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During the past **4 weeks**

8. Have you felt calm and peaceful?

____All of the time _____Most of the Time _____Some of the Time_____All of the Time_____None of the Time

10. Did you have a lot of energy?

____All of the time _____Most of the Time _____Some of the Time_____All of the Time_____None of the Time

11. Have you felt down-hearted and blue?

____All of the time _____Most of the Time _____Some of the Time_____All of the Time_____None of the Time

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During the past **4 weeks**, how much of the time has your physical health or emotional problems interfered with your social activities? (visiting friends, relatives, etc)

____All of the time _____Most of the Time _____Some of the Time_____All of the Time_____None of the Time

Thank you for taking the time to answer these questions, they will help me in providing you the best and most accurate care!