Urogyn Initial Visit Packet

Please complete the questions. If they do not apply you can skip to the next question or the next section whichever is appropriate. Thanks so much for your time. This will help to make your time in the office better utilized.

Indicates a required field.

Bladder Control Problems- This group of Questions are related to accidental loss of urine. (If you do not have this problem you may skip to Bladder Emptying Problems)
Do you have problems with accidental loss of urine or urine urgency/frequency?

Yes No

How long have you had bladder problems?

Days Weeks Months Years

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)
Select 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.

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

If you have seen a doctor for accidental loss of urine, who was that doctor? (if you have not you can type N/A or just skip the question)

Have you been prescribed a medication for accidental loss of urine and if so what was the name of the medication? (If you have not used any medication for this problem you can type N/A or skip this question)

Bladder Emptying Problems (Please answer questions related to Bladder Emptying Problems only if it is applicable to you, otherwise you can skip to the next section)
Do you have problems with emptying your bladder completely? (If you do not have bladder emptying problems you can skip to the next group of questions)

Yes No

Do you usually have difficulty starting your urine stream?

Yes No

How long have you had bladder emptying problems?

Days Weeks Months Years

Do you notice any dribbling of urine when you stand after passing urine?

Yes No

Do you have to assume abnormal positions to urinate?

Yes No

Do you have to strain or valsalva to empty your bladder?

Yes No

Describe your urine flow:
Select all that apply.

Strong Weak Dribbling Intermittent

Please answer the next group of questions related to prolapse and vaginal support issues only if they apply to you. Otherwise you can skip to the next section.
Do you have a feeling of fullness or pressure, bulge or protrusion of any vaginal tissue? (if No you can skip to the next group of questions related to bowel symptoms)

Yes No

Do you notice a bulge from the vagina when wiping or bathing?

Yes No

How long have you had a prolapse or bulge?

Days | Weeks | Months | Years

Are your symptoms worse at the end of the day or after standing for prolonged periods?
Select all that apply.

No | End of day | After standing for prolonged periods | Other

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

Have you ever had surgery for protrusion or bulge of vaginal tissue?

Yes | No

Bowel Symptoms (Please answer the following quesions related to Bowel Symptoms. If you do not have any issues please skip this section and go to the next section)
Do you have problems with your bowels? (For example accidental loss of solid or liquid stool that occurs at least once a week)

Yes | No

If you have accidental loss of solid or liquid stool, how many episodes/week do you have?

Do you wear protective pads for this problem?

Yes | No

How many protective pads/day do you use? (If you do not use protective pads for this problem you may skip this quesiton)

When you need to have a BM do you have difficulty emptying your bowels?

Yes | No

Do you have constipation?

Yes | No

Do you feel your bowels are never completely empty?

Yes | No

Do you ever place your fingers in your vagina or between the vagina and rectum to help with a bowel movement?

Yes | No

Have you seen a physician for bowel symptoms? (If so please provide the physician's name that you have

seen for bowel symptoms)

Sexual History (Please answer the questions as they pertain to you)
Are you sexually active?

Yes No

If not sexually active, are barriers due to prolapse (vaginal bulging)?

Yes No

If not sexually active, are barriers due to incontinence?

Yes No

If not sexually active, are barriers due to pain?

Yes No

Pelvic Pain (Please answer questions related to pelvic pain if they apply to you otherwise you can skip to the next section)
Do you have pain in your pelvic area?

Yes No

Where is your pain?
Select all that apply.

Pelvic Area Vagina Rectum Lower abdomen

How long have you had pelvic pain?

Days Weeks 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 relieves your pain?

Do you see a pain specialist for pelvic pain? (Please type in the name of the physician that you see related to pelvic pain)

Gynecology History (Please answer questions that are applicable to your history)

Number of times you've been pregnant?

Number of vaginal deliveries

Number of C-sections

How many children were born alive?

Medical/Surgical Questions not included in History Questionnaire

Have you had a hysterectomy (your uterus removed)?

No | Yes, Removed through vagina | Yes, Abdominal incision (large abdominal incison) | Yes, Laporoscopy (several small abdominal incisions using camera)

Have either of your ovaries been removed?

No | Yes - 1 | Yes - Both

Please list any physicians that you see other than your Primary Care Provider. (Please include their specialty ie: Cardiology, Oncology, Surgeon, etc)

List all medications, doses, and frequency that you take.

List all allergies that you currently have.