HHMA PELVIC CARE CENTER

Welcome!

New Patient Initial Medical and Surgical History
& 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 Referring Physician

WHAT IS THE PRIMARY REASON FOR COMING TO THE HHMA PELVIC CARE CENTER

Urinary incontinence
Fecal (stool) incontinence
Constipation
Pelvic Pain
Other_____

PAST GYNECOLOGIC HISTORY if applicable

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

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

cramps? Yes No
Are you taking estrogen replacement therapy? Yes No
If yes, what type?_____

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 SURGIAL HISTORY

Please circle "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 plasctic 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 if applicable

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

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 circle all symptoms that apply to you:

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

Please answer these questions by circling 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?
   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 sensation 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

PELVIC FLOOR IMPACT QUESTIONNAIRE

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. 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 one a month	Never

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. 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. 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. Do you feel pain during sexual intercourse?

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

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

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

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

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
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)?

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
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?

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

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. 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. 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