

Previous Surgeries or other Medical Conditions: (If additional space is required, please use reverse side of form.)

Type: _____ Date: _____

Family Health History

Have family members had any of these health problems?

- | <u>Yes</u> | <u>No</u> | | <u>Yes</u> | <u>No</u> | | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|----------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Gynecological Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Neurological Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Disorders | <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast Disease | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke | | | | <input type="checkbox"/> | <input type="checkbox"/> | Other |

Reason for this visit: _____
How long has this been a problem? _____ Has it been treated in the past? Yes No
Who treated it? _____ How was it done? _____
What do you want to accomplish by coming here? _____

Bowel History

Diarrhea: Yes No Frequency: _____ What do you use? _____
Constipation: Yes No Frequency: _____ What do you use? _____
Does it work? Yes No
How often do you have a bowel movement? _____ At what time of day does it occur? AM PM
When did you last have a bowel movement? _____
Do you have incontinence of your bowels? No Yes
If yes, please describe: _____

Special Diet: _____ Ordered by your provider? No Yes
Do you consume spicy, fatty, acidic foods or NutraSweet? No Yes How often? _____
If yes, please describe: _____

Fluid Intake: _____ oz/day Caffeine Consumption (Cola, Coffee, Tea, Chocolate): _____ oz/day

Alcohol Consumption Information

Type:	Amount Per:					
Wine	Day _____	Week _____	Month _____	Year _____	None _____	
Beer	Day _____	Week _____	Month _____	Year _____	None _____	
Mixed Drinks	Day _____	Week _____	Month _____	Year _____	None _____	

Do you currently smoke? No Yes How many cigarettes per day? _____ pack(s) per day
Have you ever smoked? No Yes When did you quit? _____
How many years have/did you smoked? _____
Recreational Drugs: No Yes
Types: _____
Amount: _____

Sleep Pattern

How many hours at a time do you sleep at night? _____

Do you feel rested when you awake? Yes No Occasionally

Do you use anything to help you sleep? Yes No Occasionally

If yes, what do you use? _____

Do you nap? Yes No Occasionally

Functional Status

Are you able to walk independently? Yes No

Do you use an assistive device? Yes No What do you use? _____

Do you drive? Yes No

Do you need assistance with

Bathing? Yes No Occasionally

Dressing? Yes No Occasionally

Do you have problems with your memory? Yes No If yes, please describe: _____

Do you have problems expressing yourself? Yes No If yes, please describe: _____

Do you exercise on a regular basis? Yes No What do you do? _____

Female Functions

Date of last PAP Smear: _____ Results: _____

Date of last Mammogram: _____ Results: _____

Number of pregnancies: _____ Number of births: _____ Are you currently pregnant? Yes No

Number of vaginal deliveries: _____ Number of Caesarean sections: _____

Forceps delivery? Yes No Episiotomy/Tear? Yes No

Date of last menstrual period: _____ Hysterectomy: Yes No Menopause: Yes No

Notes: _____

Male Functions

Date of last prostate exam: _____ Results: _____

Date of last PSA test: _____ Results: _____

Are you able to attain erections? Yes No If no, when was the last time? _____

Have you had prostate problems/surgery? Yes No

Describe: _____

Notes: _____

Bladder History

How often do you empty your bladder during the day?

Every: 30 minutes one hour two hours three hours four or more hours

How many times do you get up at night to urinate?

Do you leak urine? Yes No

How often do you leak urine? Every Day 2 to 3 times a week Rarely

Do you leak urine with coughing or laughing? Yes No

Do you leak with physical activity? Yes No

Do you leak on the way to the toilet? Yes No

Do you leak urine with a strong urge? Yes No

Do you lose urine during sleep? Yes No

Do you lose urine with sexual intercourse? Yes No

Do you have trouble emptying your bladder? Yes No

Do you have to strain to urinate? Yes No

Do you dribble after emptying your bladder? Yes No

Have you noticed something falling down from the vaginal area? Yes No

If yes, for how long? _____

Notes:

Quality of Life

How does your urinary incontinence, fecal incontinence or prolapse affect:

Household chores? Not at all Slightly Moderately Greatly

Physical recreation? Not at all Slightly Moderately Greatly

Entertainment activities? Not at all Slightly Moderately Greatly

Traveling greater than 30 minutes away from home?

Not at all Slightly Moderately Greatly

Social activities? Not at all Slightly Moderately Greatly

Emotional Health? Not at all Slightly Moderately Greatly

How frustrated are you with this problem? Not at all Slightly Moderately Greatly

Notes: _____
