UROGYNECOLOGY HISTORY

Name: _____ Appt Date:_____

Age: _____ Date of Birth: _____ Date Completed:_____

Reason for Visit: _____

PLEASE PROVIDE NAME, ADDRESS, PHONE, AND FAX NUMBERS FOR THE FOLLOWING PHYSICIANS OR HEALTHCARE PROVIDERS:

Referring Physician: _____ Phone: _____ Fax: _____

Address: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Address: _____

Regular Gynecologist: _____ Phone: _____ Fax: _____

Address: _____

URINARY INCONTINENCE

Do you have any accidental loss of urine? ☐ Yes ☐ No

How long have you had leakage of urine? *(number amount)* (*circle one)* Years Months

Do you wear pads to absorb lost urine? ☐ Yes ☐ No

If yes, what size pad do you wear? *(circle one)* Liner Pad Diaper

How many pads/diapers do you wear in a day?

How many trips to the bathroom do you make during the day from the time you wake up until you go to sleep at night?

(write in number amount)

How many times are you awakened during the night by an urge to urinate?

Do you get sudden bouts of urgency? ☐ Yes ☐ No

Do you have loss of urine with urge trying to get to the restroom? ☐ Yes ☐ No

If yes, how often? *(multiple times/day, 1-2 times/day, 1-2 times/week, etc)*

If yes, how much? *(circle one)* small amount moderate amount large amount

Do you lose urine during coughing, sneezing, running, or lifting? ☐ Yes ☐ No *(circle one)* Always Sometimes

Do you lose urine with changes in posture, standing, or walking? ☐ Yes ☐ No

Do you lose urine continuously such that you are constantly wet? ☐ Yes ☐ No

Do you leak with simple maneuvers such as reaching, bending, or stooping? ☐ Yes ☐ No

Has a physician evaluated or treated you for complaints of urine loss? ☐ Yes ☐ No

Have you taken medication to prevent urine loss? ☐ Yes ☐ No

If you've taken medication to prevent urine loss, which medication(s)?:

Have you had surgery to prevent urine loss?

If yes, was it done through the: *(circle one)* vagina or abdomen

Do you have any problems or difficulty with urination? ☐Yes ☐No

Have you ever required catheterization for the inability to pass urine? ☐Yes ☐No

UTI'S

Have you had three or more urinary tract infections (UTI) in the past 12 months? ☐Yes ☐No

What are your symptons with UTI's?

Have you had positive cultures? ☐Yes ☐No

How long after starting antibiotics do you feel significantly better?

Are your UTI's related to intercourse? ☐Yes ☐No

GENITOURINARY PROLAPSE

Do you have a bulge or mass beyond the opening of your vagina? ☐Yes ☐No At the opening? ☐Yes ☐No

How many months or years have you had this bulge or mass?

Have you seen a doctor for this bulge or mass in your vagina? ☐Yes ☐No

Have you worn a pessary for this problem? ☐Yes ☐No

If yes, how many months or years have you worn this pessary?

Have you had surgery in the past for a bulge or fallen pelvic organs? ☐Yes ☐No

PAST OBSTETRICAL HISTORY

Number of pregnancies: Number of C-Sections: Number of vaginal births:

SEXUAL HISTORY

Are you sexually active? ☐Yes ☐No ☐No need (menopausal)

If sexually active:

Do you use contraception? ☐Yes ☐No *If yes, what type?:*

If not sexually active, please select from the following: *(circle any that apply)*

No partner Partner factor Loss of sex drive Painful intercourse Because of bulge or leak symptoms

Other Reason *(List other reason here)*

Partner: ☐Male ☐Female ☐Both

Do you have pain with intercourse? ☐Yes ☐No

If yes, where?: (circle any that applies)

Near vaginal opening Inside abdomen/pelvic area Both

Entire act or just with deep intercourse?

Is the pain *(circle one)* Mild Moderate Severe

Percentage of intercourse with pain?

Vaginal dryness? ☐Yes ☐No

Patient Name: _____ *DOB:* _____ *Appt Date:* _____

If you have pain with intercourse, have you used outside lubricant?

If yes, did it help?

PAST GYN HISTORY

Have you ever gone through menopause? ☐ Yes ☐ No *If yes, at what age?*

Have you had any vaginal bleeding or spotting since menopause? ☐ Yes ☐ No

Have you had a hysterectomy? ☐ Yes ☐ No

If yes, was it done through *(circle one)* the vagina the abdomen laparoscopically robotically

Do you have your ovaries? ☐ Yes ☐ No *If yes:* ☐ Both ☐ One

CONSTIPATION

Describe your bowl problem: *(infrequent bowel movements? excessive straining? both? Need to use hands to assist?)*

When did this problem begin?:

How do you control this problem?:

How frequently do your bowels move?:

FECAL INCONTINENCE

Are you troubled with accidental loss of stool?

Do you have to wear a pad for leakage of stool? ☐ Yes ☐ No

Are you ever troubled with losing stool when your bowel movements are solid? ☐ Yes ☐ No

Do you have trouble with losing stool when you have diarrhea or loose stools? ☐ Yes ☐ No

How often do you have accidental leakage or loss of the following: *(circle response)*

Liquid/Loose Stool: 2 or more times/day Once daily 2 or more times/week Once weekly 1-3 time/month Never

Solid Stool: 2 or more times/day Once daily 2 or more times/week Once weekly 1-3 time/month Never

Amount of stool lost in incontinent episodes *(circle one)* Stain Small Amount Large Amount

List all medications you are currently using to control your bowls:

Do you have a history of: *(circle any that apply)*

Ulcerative Colitis Bowel Cancer Chron's Disease Irritable Bowel Syndrome (IBS)

HISTORY OF BOWEL STUDIES: *(select any that apply)*

☐ Colonoscopy *Date:*

☐ X-Ray Transit Study *Date:*

☐ Defecography *Date:*

Patient Name: _____ *DOB:* _____ *Appt Date:* _____

MEDICAL HISTORY AND FAMILY HISTORY *(Check if you or your family member have had any of the following)*

Self	*Mother's Family*	*Father's Family*	
☐	☐	☐	Diabetes
☐	☐	☐	Heart Trouble
☐	☐	☐	High Blood Pressure
☐	☐	☐	Asthma
☐	☐	☐	Blood Disease (Anemia, Sickle Cell, Etc.)
☐	☐	☐	Arthritis
☐	☐	☐	Stroke
☐	☐	☐	Psychiatric Disease
☐	☐	☐	Cancer *if yes, what type?*
☐	☐	☐	Migraines
☐	☐	☐	Blood Clots in legs or lungs (pulmonary embolism)
☐	☐	☐	High Cholesterol
☐	☐	☐	Lung Disease (COPD, Emphysema)
☐	☐	☐	Thyroid Disease
☐	☐	☐	Liver Disease (Hepatitis, Cirrhosis)
☐	☐	☐	Kidney Disease
☐	☐	☐	Epilepsy/Seizures/Convulsions
☐	☐	☐	History of Substance Abuse
☐	☐	☐	GERD (gastric reflux)
☐	☐	☐	Osteoporosis

Additional Medical Problems *(Please list here):*

Allergies to Medications (*Please list here and include the reaction):*

HOSPITALIZATIONS AND/OR SURGERIES

(Date)	*(Diagnosis/procedure)*
(Date)	*(Diagnosis/procedure)*
(Date)	*(Diagnosis/procedure)*
(Date)	*(Diagnosis/procedure)*
(Date)	*(Diagnosis/procedure)*
(Date)	*(Diagnosis/procedure)*
(Date)	*(Diagnosis/procedure)*
(Date)	*(Diagnosis/procedure)*

Patient Name: _____ *DOB:* _____ *Appt Date:* _____

CURRENT PRESCRIPTION MEDICATIONS:

SOCIAL HISTORY

☐Married ☐Single ☐Divorced ☐Widowed

Tobacco use *(smoke or chew)* ☐Yes ☐No *If yes, what type:*

How much? *(per day) x* *(number of years)*

Alcohol use ☐Yes ☐No *If yes, what type:*

How much? *(per day) x* *(per week)*

Recreational Drugs ☐Yes ☐No *If yes, what type:*

How much? *(per day) x* *(per week)*

Caffeine ☐Yes ☐No *If yes, source:*

How much? *(per day) x* *(per week)*

Exercise ☐Yes ☐No *If yes, specify type:* *How often?*

Occupation

Do you need assistance with bathing, dressing, cooking, or cleaning? ☐Yes ☐No

MARK ALL SYMPTOMS YOU <u>CURRENTLY</u> HAVE:

General: ☐fever ☐chills ☐weight loss/gain

Eyes: ☐blurring ☐double vision

Ears, Nose, Throat, Mouth:
☐congestion ☐decreased hearing

Respiratory: ☐shortness of breath ☐cough ☐wheezing

Cardiovascular: ☐chest pain ☐swelling/fluid retention

Gastrointestinal: ☐indigestion/heartburn ☐nausea
☐vomiting ☐abdominal pain

Genitourinary: ☐burning/painful urination
☐blood in urine ☐genital sores ☐abnormal periods

Musculoskeletal: ☐body ache
☐joint pain (area)_____

Skin: ☐itching ☐rashes

Neurological: ☐tingling (area)_____
☐numbness ☐paralysis

Psychiatric: ☐anxiety ☐memory loss ☐depression

Endocrine: ☐excessive sweating ☐thirst

Hematological/Lymphatic: ☐swollen glands
☐anemia

Allergic/Immunologic: ☐itching ☐hives ☐swelling
☐hay fever

Reproductive Health: ☐currently sexually active
☐history of sexually transmitted disease
☐sexual problems

Patient Name: _____ *DOB:* _____ *Appt Date:* _____

UROGYNECOLOGY

Welcome to our practice. We look forward to seeing you!

To ensure that Dr. Agosta is able to gather all the information critical to your diagnosis and treatment, it is important that the following information is reviewed and completed **PRIOR to your appointment:**

Enclosed is the following:

1. **Registration Information**
2. **Medical History Form**
3. **Urinary Diary Form** *This needs to be completed for two 24-hour periods.*

Please arrive **20 MINUTES PRIOR** to your appointment for registration.

If you cannot keep your appointment, please call more than 24 hours in advance to cancel or reschedule.

No-show or less than 24 hour cancellations may incur a $50 fee.
Repetitive occurances may result in removal from the practice.

If you have any questions, please call the office.

Thank you!

URINARY DIARY

NAME:_____ **DOB:**_____

1. Please keep track of your urine output for **TWO FULL 24-HOUR PERIODS.** They do not have to be consecutive days.
2. Please include **A.M.** or **P.M.**
3. Write down **wake-up time** and **bedtime**.
4. Document the **time of urination**.
5. Measure the amount you urinate in **ounces or ml's**.
6. Any plastic measuring container can be used and discarded.
7. Please indicate any time you accidentally leak urine and cause for the accident. (example: coughing, laughing, urgency)
8. **If you do not have access to a measuring container, notify us and we will give you a Urinary Hat.**

Example:	***TIME***	***AMOUNT***
	8:00 A.M. Wake-up	8 Ounces
	10 A.M.	Less than 1 ounce
	9:30 P.M. Bedtime	Leaked Urine (Coughing)

DAY 1 DATE: _____ **DAY 2 DATE:** _____

TIME	AMOUNT	TIME	AMOUNT

DAY 1 DATE: ______________________________ DAY 2 DATE: ______________________________
