Billings Clinic Urogynecology

Patient Name:______________________________ Date of Birth: ______ Visit Date:_________

Please complete this questionnaire prior to arriving at the clinic so that we can be better prepared to address your particular health care needs.

Provider who **referred** you:	Your **Primary Care Provider**:
Name_______________________________________	Name_______________________________________
Address_____________________________________	Address_____________________________________
City_______________ State_____ Zip Code______	City_______________ State_____ Zip Code__________
Phone number:_______________________________	Phone number:_______________________________
Fax number:_________________________________	Fax number:_________________________________

Please list the name of your pharmacy:

Name____
Address____
City________________ State_______ Zip Code_______
Phone number: ___________________________________

If you are cared for by a **cardiologist** please list below:	Please list the names and addresses of any other doctor you would like us to communicate with:
Name_______________________________________	Name_______________________________________
Address_____________________________________	Address_____________________________________
City______________ State____ Zip Code________	City______________ State____ Zip Code______________
Phone number:_______________________________	Phone number:_______________________________
Fax number:_________________________________	Fax number:_________________________________

What is the **reason for your visit**? ____
____
____

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Please list the things you are **allergic** to **AND** your reaction to it. Include medications, food, and environmental allergies.

☐ **I do not have any allergies**

Medicine/Food/Other Allergies:	Reaction:
___	___
___	___
___	___
___	___

Have you ever used any medicines to help control your bladder or bowels? List all that apply:___________________
____ ☐ I have not used medications.

Please list the **medicines are you currently taking.** Include all over the counter **(OTC)** medications like vitamins, herbs, remedies and supplements.

Medicine/OTC Medicine	Dose	Medicine/OTC Medicine	Dose
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	

Please answer the following questions about **urination:**

How frequently do you urinate during the day?	Every ________ hours	
How many times do you get up at night to urinate?	__________ times	
Do you ever wet the bed?	☐ Yes	☐ No
Do you feel you completely empty your bladder?	☐ Yes	☐ No

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Do you have trouble starting your stream of urine?	☐ Yes	☐ No
Do you notice any change in your stream of urine?	☐ Yes	☐ No
Do you ever dribble urine?	☐ Yes	☐ No
Do you need to wear pads for protection from urine leakage?	☐ Yes	☐ No
Have you had 3 or more urinary tract infections in the past year?	☐ Yes	☐ No
Have you ever used a pessary for prolapse or incontinence?	☐ Yes	☐ No

On an average day, how much do you drink? List below.

Type of Fluid	Amount	Type of Fluid	Amount
Example: decaf coffee	*2 8oz cups*		

Please answer the following questions about your **OBSTETRICAL AND GYNECOLOGIC HISTORY:**

How many times have you been pregnant?	___________________ Times	
How many children did you deliver?	_____________________	
Of these, how many were delivered:	_________________Vaginally	____________________By C-Section
	Forcep Assisted? ☐ Yes ☐ No	Vacuum Assisted? ☐ Yes ☐ No
How big was your biggest baby?	_______lbs. _______oz.	
What was your age at each delivery?	_________________________	
Did you have any problems with any of your deliveries?	☐ Yes Explain:____________________	☐ No

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Have you experienced menopause?

☐ Yes – **please answer questions 1-3 only**	☐ No – **please answer questions 4-7 only:**
1. How old were you when you went through menopause? _______ years old	4. Date of your Last Menstrual Period: ______________________________
2. Do you take hormone replacements? ☐ Yes ☐ No 2a. If yes, list the type:_________________ ___________________________________	5. Periods come every _______days and lasts _________ days. 6. Do you have problems with your periods? ☐ Yes ☐ No
3. How long have you taken hormone replacement? ________________________years	7. Do you use Birth Control? ☐ Yes ☐ No If yes list method: ______________________________

Are you sexually active?	☐ Yes	☐ No	
Is sexual intercourse painful for you?	☐ Yes	☐ No	
Do you leak urine during intercourse?	☐ Yes	☐ No	
In your life, have you ever been sexually or physically abused?	☐ Yes	☐ No	
Have you ever had an abnormal Pap smear? Did you have to have treatment?	☐ Yes ☐ Yes	☐ No ☐ No	Date of last Pap smear: ______________ What type?
Have you had an abnormal mammogram?	☐ Yes	☐ No	Date of last mammogram:
Have you ever had an abnormal colon screen?	☐ Yes	☐ No	Date of last colon screening: (colonoscopy or sigmoidoscopy)
Have you ever had pelvic radiation for any reason?	☐ Yes	☐ No	
Have you ever tried using a pessary?	☐ Yes	☐ No	

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Please answer these questions about your **MEDICAL HISTORY.**

Do you have any of the following conditions? Check all appropriate boxes.

Heart Problems	**Lung Problems**	**Bowel Problems**	**Neurologic Problems**
☐ Heart Disease	☐ Asthma	☐ Bowel Disease	☐ Parkinson's Disease
☐ High Blood Pressure	☐ Pneumonia	☐ Ulcers	☐ Multiple Sclerosis
☐ Heart Murmur	☐ Tuberculosis	☐ Diverticulitis	☐ Stroke
☐ Heart Attack	☐ Emphysema	☐ Liver disease	☐ Back injury, surgery, known herniated disc
☐ High Cholesterol/Lipids		☐ Diverticulosis	
Endocrine Problems	**Bleeding problems**	**Other**	
☐ Diabetes	☐ Bleeding problem	☐ Kidney Disease	
☐ Thyroid Disease	☐ Blood clot problem	☐ Arthritis	
☐ Osteoporosis	☐ Aspirin use	☐ Glaucoma	
☐ Chronic Steroid Use		☐ Cancer	

Please tell us more about anything that was checked above, or about any other problems:

____

____

____

SURGICAL HISTORY

List **all** surgeries you have had and the approximate year:

Surgery	*Year*	*Surgery*	*Year*
______________________	________	______________________	________
______________________	________	______________________	________
______________________	________	______________________	________
______________________	________	______________________	________
______________________	________	______________________	________
______________________	________	______________________	________
______________________	________	______________________	________
______________________________		______________________________	
______________________________		______________________________	

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Are you **currently** having any problems with any of the following: (check all that apply)

Constitutional	Eyes	Gastrointestinal	Endo/Heme/Allergies
☐ Fever	☐ Blurred vision	☐ Heartburn	☐ Easy bruising
☐ Chills	☐ Double vision	☐ Nausea	☐ Environmental Allergies
☐ Weight loss	☐ Sensitivity to light	☐ Vomiting	☐ Excessive thirst
☐ Malaise/Fatigue/Tired	☐ Eye Pain	☐ Abdominal pain	**Neurological**
☐ Intense sweating	☐ Eye Discharge	☐ Diarrhea	☐ Dizziness
☐ Weakness	☐ Eye Redness	☐ Constipation	☐ Tingling
Skin		☐ Blood in stool	☐ Tremors/shaking
☐ Rash		☐ Black, tarry stool	☐ Sensory changes
Head/Ears/Nose/Throat	**Cardiovascular**	**Genitourinary**	☐ Speech changes
☐ Headache	☐ Chest pain	☐ Painful urination	☐ Focal weakness
☐ Hearing loss	☐ Heart palpitations	☐ Urgency	☐ Seizures
☐ Ringing in ears	☐ Shortness of breath when lying flat	☐ Frequency of urination	☐ Loss of consciousness
☐ Ear pain	☐ Cramps in lower legs	☐ Blood in urine	**Psychological**
☐ Nosebleeds	☐ Leg swelling		☐ Depression
☐ Congestion	**Respiratory**	**Musculoskeletal**	☐ Suicidal thoughts
☐ Sore throat	☐ Cough	☐ Muscle pain	☐ Substance abuse
	☐ Coughing up blood	☐ Neck pain	☐ Hallucinations
	☐ Excess sputum	☐ Back pain	☐ Nervousness/Anxiety
	☐ Shortness of breath	☐ Joint pain	☐ Insomnia
	☐ Wheezing	☐ Falls	☐ Memory Loss

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Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, how much they bother you. Answer these by putting an **X** in the appropriate box or boxes. While answering these questions, please consider your symptoms over the **last 3 months.**

Pelvic Organ Prolapse Distress Inventory

Do you________? **If yes,** how much does it bother you?

	Not at all	*Somewhat*	*Moderately*	*Quite a bit*
Usually experience *pressure* in your lower abdomen? ☐ **Yes** ☐ **No**				
Usually experience *heaviness* or *dullness* in the pelvic area? ☐ **Yes** ☐ **No**				
Usually have a bulge or something falling out that you can see or feel in your vaginal area? ☐ **Yes** ☐ **No**				
Ever have to push on the vagina or around the rectum to have or complete a bowel movement? ☐ **Yes** ☐ **No**				
Usually experience a feeling of incomplete bladder emptying? ☐ **Yes** ☐ **No**				
Ever have to push up on a bulge in the vaginal area with your fingers To start or complete urination? ☐ **Yes** ☐ **No**				

Colorectal-Anal Distress Inventory

Do you________? **If yes,** how much does it bother you?

	Not at all	*Somewhat*	*Moderately*	*Quite a bit*
Feel you need to strain too hard to have a bowel movement? ☐ **Yes** ☐ **No**				
Feel you have not completely emptied your bowels at the end of a bowel movement? ☐ **Yes** ☐ **No**				
Usually lose stool beyond your control if your stool is well formed? ☐ **Yes** ☐ **No**				
Usually lose stool beyond your control if your stool is loose? ☐ **Yes** ☐ **No**				
Usually lose gas from the rectum beyond your control? ☐ **Yes** ☐ **No**				
Usually have pain when you pass your stool? ☐ **Yes** ☐ **No**				
Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement? ☐ **Yes** ☐ **No**				
Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement? ☐ **Yes** ☐ **No**				

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Urinary Distress Inventory

Do you usually experience_______?		If yes, how much does it bother you? Not at all	Somewhat	Moderately	Quite a bit
frequent urination?	☐ Yes ☐ No				
urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	☐ Yes ☐ No				
urine leakage related to coughing, sneezing, or laughing?	☐ Yes ☐ No				
small amounts of urine leakage?	☐ Yes ☐ No				
difficulty emptying your bladder?	☐ Yes ☐ No				
pain or discomfort in the lower abdomen or genital region?	☐ Yes ☐ No				

DAILY ACTIVITIES

What kind of work do you do?____

Do you exercise regularly? ☐ **Yes** ☐ **No** If yes, how many hours per week? __________

What types of exercise do you do?____

Who is your main support person (partner, spouse, friend)?____

Do you consider yourself healthy? ☐ Yes ☐ No

Do you currently smoke? ☐ Yes ☐ No How many packs a day?_____________________

Exposed to secondhand smoke? ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ No

Starting at what age? _________

Ending at what age? __________ How many packs a day? _____________________

How many cans of beer__________, glasses of wine________ , or alcohol ________(oz) do you drink every week?

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FAMILY HISTORY

Please note if anyone in your family has a history of any of these diseases. **Please specify mother or father's side.**

			Family Member(s)
Breast Cancer	☐ Yes	☐ No	______________________
Ovarian Cancer	☐ Yes	☐ No	______________________
Other Cancer	☐ Yes	☐ No	______________________
Heart Disease	☐ Yes	☐ No	______________________
Diabetes	☐ Yes	☐ No	______________________
High blood pressure	☐ Yes	☐ No	______________________
Osteoporosis	☐ Yes	☐ No	______________________
Urinary incontinence	☐ Yes	☐ No	______________________

Other ____

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 are being affected by your bladder, bowel, or vaginal symptoms or conditions **over the last 3 months**. Please make sure you mark an answer in **all 3 columns** for each question.

How do symptoms or conditions related to the following →→ usually affect your ↓	**Bladder or urine**	**Bowel or rectum**	**Pelvis or vagina**
1. Ability to do household chores (cooking, housecleaning, laundry)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
3. Entertainment activities such as going to a movie or concert?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

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4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
5. Participating in social activities outside your home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
6. Emotional health?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
7. Frustration?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

Patient Signature:____ Date:__________ Time:_________

Thank you so much for your time in completing this form. We look forward to seeing you.

Patient Label