MOUNTAIN STATES UROGYNECOLOGY
New Patient Medical History Questionnaire

PLEASE PRINT, THANK YOU! Date of Appointment_____/_____/_____

Name_____ **Date of Birth**_____/_____/_____

Referring Doctor_____ Primary Care M.D._____

What is the main reason for your visit? (please mark box)

☐ Urinary leakage with cough/sneeze/exercise ☐vaginal bulging-dropped bladder/uterus/rectum
☐ Frequent urination ☐ bladder infections ☐ Dribbling after urination ☐Pelvic/vaginal pain
☐ inability to postpone urination ☐ vulvar pain ☐painful urination ☐constipation
☐ Interstitial cystitis ☐ frequent urination at night ☐ ovarian cysts ☐ fibroids
☐ urethral cyst/diverticulum ☐ unable to empty bladder ☐ loss of bowel control

Other (please list)_____

How long has this problem bothered you?_____

What are your expectations in seeking help for this problem?
☐ complete cure ☐ reduce severity of symptoms ☐ want diagnosis
☐ other(explain):_____

SURGICAL HISTORY
Have you had any previous surgery for incontinence? ☐ No ☐ Yes
Type and Date:_____
Have you had any previous surgery for pelvic relaxation/prolapse? ☐ No ☐ Yes
Type and Date:_____

Have you had a hysterectomy? ☐ No ☐ Yes: ☐ Abdominal ☐ Vaginal
Have your ovaries been removed? ☐ No ☐ Yes
Have you had any other procedures on the urinary tract? ☐ No ☐ Yes: if yes, please mark
☐ urethral dilation ☐ cystoscopy ☐ urodynamics (bladder testing)
☐ collagen injections ☐ bladder distension ☐ kidney stone treatment

Any other surgeries (heart, gall bladder, appendix, tubal ligation, etc)? ☐ No ☐ Yes
Type and Date:_____
_____

GYNECOLOGIC HISTORY
Describe your current periods: ☐ Regular ☐ Irregular ☐ Painful periods
☐ Heavy ☐ Perimenopause ☐ Post-Menopause, Age:_____

Date of last normal menstrual period:___/___/_____

Date of last PAP: ___/___/____ ☐ Normal ☐ Abnormal
Follow up for abnormal PAP_____

History of pelvic infections? ☐ No ☐ Yes: if yes, please list_____
Date of Last Mammogram: ☐ None _____/_____ ☐ Normal ☐ Abnormal
Date of last colonoscopy screening: ☐ None _____/_____ ☐ Normal ☐ Abnormal

Provider Reviewed_____

OBSTETRIC HISTORY

Total number of times pregnant_____

Have you had any vaginal (natural) deliveries? ☐ No ☐ Yes: Number_____
☐ Forceps Assisted ☐ Episiotomy___Largest Baby:_____lbs._____oz.

Have you had any Cesarean deliveries? ☐ No ☐ Yes Number_____

Any miscarriages? ☐ No ☐ Yes: Number_____ Any abortions?☐ No ☐ Yes: Number_____

MEDICAL HISTORY (please mark any conditions that apply to you)

___ High blood pressure	___ Heart Disease	___ Diabetes	___ Thyroid
___ Fibromyalgia	___ IBS	___ Asthma/COPD	___ Skin Dz
___ Arthritis	___ Reflux/GERD	___ Cancer	___ Depression
___ IBD/colitis	___ Neurologic	___ Kidney stones	___Heart Attack
___ Blood clots	___ Back/spine/disk problems or pain		

Please list any other conditions or details from those marked above:

_____
_____
_____
_____

****Please List Medications with dose and how often taken**

CURRENT MEDICATIONS:(List all: **birth control, over the counter meds, vitamins, supplements, and herbs)**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES: **List allergies to medications and substances and type of reaction**

☐ **No drug allergies** ☐ **Latex allergy** ☐ **Betadine/Iodine allergy**

_____
_____

SOCIAL HISTORY AND HEALTH HABITS: (Check all that apply)

Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

(Check all that apply)

Yes	No	Are you / or do you…	**Notes**
		A smoker?	Cigarettes per day: How many years?
		Drink alcohol?	What type and how often?
		Use illegal drugs (metamphetamine, cocaine, marijuana, heroin, etc.)?	What type and how often?
		Wear your seat belt?	
		Exercise regularly?	
		Take extra calcium?	
		Drink caffeine (coffee, tea,)?	Cups/day:
		Sexually Active?	My partner is…☐ Male ☐ Female ☐ Both
		Do self-breast exams (SBEs)?	

Name_____ Date_____Provider Reviewed_____

Family Health: Includes only father, mother, siblings, and grandparents. (Check all that apply.)

Yes	No	Disease	Please list family member with condition
		Heart Disease	
		High blood pressure	
		Blood clots in lungs/legs	
		Stroke	
		Diabetes	
		Thyroid Disease	
		Kidney Disease	
		Cancer (please list type)	
		Arthritis	
		Mental Illness/Depression	
		Blood Disease	
		Bladder or Prolapse problems	
		Other	

Review of Systems:

Do you **now** have any problems related to the following systems?

General ☐ **No Problems**
☐ Fever or chills ☐ Fatigue
☐ Weakness ☐Loss of Appetite
☐ Headaches (frequent)
☐ Weight gain amount_____, time _____
☐ Weight loss amount_____, time _____

Eyes ☐ **No Problems**
☐Vision Change ☐ Glasses/Contacts: ☐ Distance ☐ Reading
☐ Glaucoma ☐ Cataracts ☐ double vision
☐ Other_____

Neurological ☐ **No Problems**
☐ Tremors ☐ Black-outs ☐ Seizures ☐ Neuropathy
☐ Other_____

Endocrine ☐ **No Problems**
☐ Diabetes ☐ low thyroid ☐ Hyperthyroid
☐ Hot flashes ☐ Heat/Cold Intolerance ☐ Chronic fatigue
☐ Other_____

Gastrointestinal ☐ **No Problems**
☐ Diarrhea ☐ Constipation ☐ Fecal incontinence
☐ Indigestion ☐ nausea and vomiting
☐ Hepatitis ☐ Rectal Bleeding ☐ Abdominal Pain
☐ Blood in stool ☐ Colon polyps
☐ Other_____

Skin ☐ **No Problems**
☐ Rash ☐Ulcers
☐ Other_____

Cardiovascular ☐ **No Problems**
☐ Chest Pain ☐ shortness of breath ☐ swelling
☐ Palpitation ☐ short of breath with exertion ☐ Blood clots
☐ High blood pressure ☐ Stroke
☐ Other_____

Ear/Nose/Throat/Mouth ☐ **No Problems**
☐ Hearing Loss ☐ Syncope ☐ Sinusitis
☐ Migraines ☐ Seasonal Allergies ☐ Colds/Cough
☐ Other_____

Genitourinary ☐ **No Problems**
☐ Urine retention ☐ Incomplete Emptying of urine
☐ Painful urination ☐ Blood in urine
☐ Urinary frequency
☐ Urinary urgency
☐ Vaginal bulge ☐ Incontinence
☐ Urinary tract infections (>3 per year)
☐ Frequent urination at night
☐ Other_____

Gynecologic ☐ **No Problems**
☐ Abnormal Vaginal Discharge ☐ STD's
☐ Pain with intercourse ☐ irregular menses
☐ Other_____

Lungs-Respiratory ☐ **No Problems**
☐ Wheezing ☐ Cough ☐ Asthma
☐ Emphysema ☐ Pneumonia ☐ Coughing blood
☐ Other_____

Hematologic/Lymphatic ☐ **No Problems**
☐ Easily Bruises ☐Bleeding gums ☐ swollen gland
☐ HIV/AIDS ☐Hepatitis
☐ Blood Transfusion When?_____
☐ Other_____

Psychologic ☐ **No Problems**
☐ Depression ☐ Severe Anxiety ☐☐ Other

Musculoskeletal ☐ **No Problems**
☐ Weakness ☐ Pain ☐ Arthritis
☐ Backache ☐Limit of motion ☐ Other

Name_____ Date_____Provider Reviewed_____

MOUNTAIN STATES UROGYNECOLOGY

Intake Questionnaire

UDI-6

1. Do you experience, and, if so, how much are you bothered by frequent urination?

   ☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Greatly*

2. Do you experience, and, if so, how much are you bothered by urine leakage related to the feeling of urgency?

   ☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Greatly*

3. Do you experience, and, if so, how much are you bothered by urine leakage related to physical activity, coughing, or sneezing?

   ☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Greatly*

4. Do you experience, and, if so, how much are you bothered by small amounts of urine leakage (drops)?

   ☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Greatly*

5. Do you experience, and, if so, how much are you bothered by difficulty emptying your bladder?

   ☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Greatly*

6. Do you experience, and, if so, how much are you bothered by pain or discomfort in the lower abdominal or genital area?

   ☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Greatly*

IIQ-7

7. Has urine leakage affected your ability to do household chores (cooking, cleaning, laundry, etc)?

   ☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Greatly*

8. Has urine leakage affected your physical recreation such as walking, swimming, or other exercise?

   ☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Greatly*

9. Has urine leakage affected your entertainment activities (movies, concerts,etc.)?

   ☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Greatly*

10. Has urine leakage affected your ability to travel by car or bus more than 30 minutes from home?

    ☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Greatly*

11. Has urine leakage affected your participation in social activities outside your house?

    ☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Greatly*

12. Has urine leakage affected your emotional health (nervousness, depression, etc.)?

    ☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Greatly*

13. Has urine leakage affected your feeling frustrated?

    ☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Greatly*

14. During an average day, how many times do you urinate?_____

15. During an average day, how often do you urinate?_____

16. During an average night, how often do you get up to urinate?_____

17. During an average day, how many pads or diapers do you use?_____

Name_____ Date_____ Provider Reviewed_____