HARBOUR WOMEN'S HEALTH

OBSTETRICS ● GYNECOLOGY ● UROGYNECOLOGY

Thank you for choosing Harbour Women's Health for your Urogynecologic needs. Enclosed is a questionnaire which will help to customize a treatment plan that addresses your needs. Thank you for taking the time to answer these questions to the best of your ability.

Sincerely,

Deeptha N Sastry, MD

Female Pelvic Medicine and Reconstructive Surgery

Urogynecology

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HARBOUR WOMEN'S HEALTH

OBSTETRICS ● GYNECOLOGY ● UROGYNECOLOGY

Name_____Date of Birth_____Date_____

Urogynecology New Patient Questionnaire

A. Urinary Symptoms

Part 1

1. Do you ever experience leakage of urine (this is called urinary incontinence)?

   ☐ Yes ☐ No

   (If No, Please skip down to Urinary Symptoms **Part 2**

2. How any times do you leak urine on an average day? _____ times per day
3. For how many years have you experienced leakage of urine? _____ Yrs
4. For how long have you felt that it is a problem? _____ Yrs _____ months
5. Do you wear pads or other protection? ☐ Yes ☐ No
6. What type of pad do you wear? ☐ Mini ☐ Regular ☐ Diaper
7. How many pads do you change per day? _____ Pads per day
8. How wet is your pad when you change it? ☐ Few drops ☐ Wet ☐ Soaked
9. Do you leak when coughing, sneezing, or laughing? ☐ Yes ☐ No
10. Do you leak when you have a strong urge to urinate? ☐ Yes ☐ No
11. Do you leak when you are asleep? ☐ Yes ☐ No

Part 2

12. About how often do you urinate during the day? Every _____hours
13. How many times do you wake at night to go to the bathroom? _____
14. Do you have frequent urinary tract infections (more than 3 per year)?

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☐ Yes ☐ No ☐ Not certain

15. How many urinary infections have you been treated for in the last year? _____

16. Do you have pain when you urinate? ☐ Yes ☐ No ☐ Sometimes

17. Have you seen blood in your urine? ☐ Yes ☐ No

18. Has a physician told you of blood in your urine? ☐ Yes ☐ No

Name_____Date of Birth_____Date_____

Urogynecology New Patient Questionnaire

B. Prolapse

19. Do you have a feeling of a bulge or something falling out of your vagina?

☐ Yes ☐ No

(If no, skip to **C. Bowel Function** #24)

20. For how long have you noticed the bulge? _____ Years

21. Have you ever worn anything in your vagina such as a pessary or tampon to prevent the sensation of bulge in the vagina? ☐ Yes ☐ No

22. Do you ever need to push on a bulge in your vagina or around your vagina in order to empty your bladder or rectum? (This is called splinting) ☐ Yes ☐ No

23. Have you ever had surgery to treat a bulge in your vagina? ☐ Yes ☐ No

24. If so, what surgery or surgeries?

_____

_____

C. Bowel Function

25. How many bowel movements do you have each week? _____ Per week

26. Do you strain to move your bowels more than 25% of the time? ☐ Yes ☐ No

27. Do you feel that having a bowel movement does not completely empty your rectum?
☐ Yes ☐ No

28. Please list medicines (including fiber supplements) that you take to control your bowel movements._____

_____

Name_____Date of Birth_____Date_____

29. Do you experience uncontrollable leakage of stool (liquid or solid) from the rectum?

☐ Yes ☐ No **If no, skip next question**

*Please note that the next question asks about only the past 1 month.

30. For each of the following, please indicate on average how often in the past 1 month you experienced any amount of accidental bowel leakage: (Check only one box per row.)

	2 or more times a day	Once a day	2 or more times a week	Once a week	1 to 3 times a month	never
Gas						
Mucus						
Liquid Stool						
Solid Stool						

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Name_____ Date_____

New Patient Questionnaire

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 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	Vagina or pelvis
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 exercises?	☐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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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
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 (nervousness, depression etc)	☐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. Feeling frustrated?	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit	☐Not at all ☐Somewhat ☐Moderately ☐Quite a bit

Name_____ Date_____

Urogynecology New Patient Questionnaire

Instructions: Following are a list of questions about you and your partner's sex life. All information is strictly confidential. Your confidential answers will be used only to help doctors understand what is important to patients about their sex lives. Please check the box that best answers the question for you. While answering the questions, consider only your sexuality over the past six months.

Are you sexually active? ☐ Yes ☐ No **If no, skip next question**

1. How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex, feeling frustrated due to lack of sex, etc.

☐ always ☐ usually ☐ sometimes ☐ seldom ☐never

2. Do you climax (have an orgasm) when having sexual intercourse with your partner?

☐ always ☐ usually ☐ sometimes ☐ seldom ☐never

3. Do you feel sexually excited (turned on) when having sexual activity with your partner?

☐ always ☐ usually ☐ sometimes ☐ seldom ☐never

4. How satisfied are you with the variety of sexual activities in your current sex life?

☐ always ☐ usually ☐ sometimes ☐ seldom ☐never

5. Do you feel pain during sexual intercourse?

☐ always ☐ usually ☐ sometimes ☐ seldom ☐never

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

☐ always ☐ usually ☐ sometimes ☐ seldom ☐never

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

☐ always ☐ usually ☐ sometimes ☐ seldom ☐never

8. Do you avoid sexual intercourse because of a bulging in the vagina (either the bladder, rectum or vagina falling out)?

☐ 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?

☐ always ☐ usually ☐ sometimes ☐ seldom ☐never

Review of Symptoms

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Name_____Date of Birth_____Date_____

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in the space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other_____

Gastrointestinal

Abdominal Pain	Y	N
Constipation	Y	N
Indigestion/Heartburn	Y	N
Diarrhea	Y	N

Other_____

Genitourinary

Difficulty Emptying Bladder	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N
Urinary Urgency	Y	N
Urinary Leaking	Y	N

Other_____

Endocrine

Excessive Thirst	Y	N
Difficulty w/Heat or Cold	Y	N
Unintentional Weight Change	Y	N

Other_____

Cardiovascular

Irregular Heartbeat / Palpitations	Y	N
Chest Pain	Y	N

Other_____

Respiratory

Wheezing	Y	N
Chronic Cough	Y	N
High Blood Pressure	Y	N

Other_____

Skin

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N

Other_____

Patient Signature:_____

Psychologic

Depression	Y	N
Anxiety	Y	N

Other_____

Ear/Nose/Throat/Mouth

Migraines	Y	N
Sinus Problems	Y	N
Hearing Loss	Y	N

Other_____

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N

Other_____

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N

Other_____

Hematologic/Lymphatic

Swollen Glands	Y	N
Bruising	Y	N

Other_____

Musculoskeletal

Muscle Weakness	Y	N
Joint Pain	Y	N
Back Pain	Y	N

Other_____

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Dry Eyes	Y	N

Other_____

Physician Notes:

_____

_____

_____

Provider Signature: _____

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