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UROGYNECOLOGY MEDICAL HISTORY QUESTIONNAIRE



Last Name

Middle Name

First Name



Date of Birth

Today's Date

Please write in your own words the nature of your current medical problem.



Please circle "T" for True or "F" for False depending on which is most accurate.

T F I leak urine.

If true, how long have you leaked urine? _____

T F I have to wear pads because of losing urine.

If true, please indicate the type of pad (panty liner, regular pads, maxi pads, etc.) and the number of pads used per day. _____

T F My bladder problem is bad enough that I would request surgery to fix it.

- T F I have had an operation on my bladder.
If so, please check: _____ Abdominal _____ Vaginal
- T F The operation I had on my bladder cured my problem.
- T F The operation I had on my bladder helped my problem for a short time.
- T F The operation I had on my bladder did not help at all.
- T F I leak urine when I cough, sneeze, exercise, or move suddenly.
- T F I lose urine in small spurts.
- T F I lose large amounts of urine and once it starts I cannot control it.
- T F If I cough hard, I leak at the same time.
- T F If I cough hard, the leaking comes a few seconds later.
- T F I often feel the urge and need to urinate even if my bladder isn't very full.
- T F I often feel the urge to urinate before I leak.
- T F I often leak when I am trying to make it to the toilet.
- T F The sound, sight or feeling of running water gives me the urge to urinate.
- T F The sound, sight or feeling of running water causes leakage of urine.
- T F If I suddenly stand up after sitting or lying down, I lose urine.

- T F I urinate more than six times a day.
- T F The need to urinate wakes me up at least two times during the night.
- T F I have had two or more bladder infections in the last year.
- T F Intercourse causes me to have bladder infections.
- T F I have pain in the area of my bladder.
- T F It hurts to urinate.
- T F I have been treated by urethral dilatation.
- T F I had trouble wetting the bed as a child.
- T F I now have trouble wetting the bed.
- T F My urine loss is a continual drop so that I am constantly wet.
- T F I have trouble starting the urine stream.
- T F My urine stream starts and stops, starts and stops.
- T F I dribble urine before and after urinating.
- T F My urine stream is no more than a dribble.
- T F It takes me a long time to empty my bladder.
- T F After I urinate I often feel that I have not completely emptied.

Bladder Record

Please keep track of your fluid intake and output for two full 24 hour days. They do not have to be consecutive days. Please include a.m. and p.m. when documenting the time of day when you urinate; and please measure the amount you urinate in ounces or milliliters (these markings can be found on a measuring cup).

This record is very important when deciding your treatment plan.

DAY ONE

TIME	AMOUNT VOIDED	ACCIDENT AMOUNT OF LEAKAGE	REASON FOR ACCIDENT	AMOUNT AND TYPE OF FLUID DRANK

Number of Pads or Undergarments Used Today? _____

DAY TWO

TIME	AMOUNT VOIDED	ACCIDENT AMOUNT OF LEAKAGE	REASON FOR ACCIDENT	AMOUNT AND TYPE OF FLUID DRANK

Number of Pads or Undergarments Used Today? _____

UROLOGY SUMMARY

	DAY ONE	DAY TWO
I/O		
TOTAL VOIDS		
MAX VOLUME		
NOCTURIA		