PIONEER VALLEY
UROLOGY, P.C.

Name: _____ Date: _____

Date of Birth: _____

New Patient History Form
FEMALE

Chief Complaint (Why do you want to see the doctor today?):

_____

_____

Incontinence/Pelvic Floor Questionnaire
(Fill in and Circle answers)

BLADDER

How many times do you urinate during the day: _____ During the night? _____

Is the amount of urine that you void a:

Large Amount
Average Amount
Small Amount

Do you experience incontinence (leakage of urine) with any of the following activities?

Coughing Y / N	Exercise Y / N	Sexual Activity Y / N
Laughing Y / N	Bending Y / N	Standing from sitting Y / N
Sneezing Y / N	Sleeping Y / N	

Some women have a very sudden overwhelming desire to urinate with very little warning and fear that they will leak urine if they do not get to the bathroom in time.

How often does this happen to you? Never / Rarely / Sometimes / Always
Can you overcome this strong desire to urinate? Never / Rarely / Sometimes / Always

If you do experience urgency(desperate desire to urinate), do you lose urine before making it to the toilet? Y / N
If YES, how often does this happen to you? Never / Rarely / Sometimes / Always

Do you lose urine when you suddenly feel that your bladder is full? Y / N

Do you lose urine with:

Handwashing Y / N Cold Weather Y / N Drinking cold beverage Y / N
Key in the door when you return home Y / N

How many protective pads do you use per day for protection?_____

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Do you have frequent urinary tract infections (UTI)? Y / N
If YES, how many UTI's in the past year?_____
Do you ever see blood in your urine? Y / N

How would you describe your urine flow when you void? Strong / Weak / Dribbling / Intermittent
Do you feel that you empty your bladder completely when you urinate? Y / N
Do you have to assume abnormal positions to urinate? Y / N
Do you have difficulty initiating urination once you sit on the toilet? Y / N
Is your urine flow continuous once you begin voiding or does it start and stop (intermittency)?
Continuous / Start/Stop

Do you ever have pain with urination? Y / N
Do you ever have pain your lower abdomen or pelvic area? Y / N
If YES, is the pain related to any of the following:
Your bladder being full Y / N
Your menstrual cycle Y / N
Sexual Intercourse Y / N
Bowel Movements Y / N

Have you had a history of incontinence as a child? Y / N
Have you had a history of bed-wetting as a child? Y / N

PROLAPSE
Do you usually experience pressure in the lower abdomen? Y / N
Do you usually experience heaviness or dullness in the pelvic area? Y / N
Do you experience a feeling of incomplete bladder emptying? Y / N
Do you usually have a bulge or something falling out that you can see or feel in your vaginal area? Y / N
Do you ever have to push on the vagina or around the rectum to have or complete a bowel movement? Y / N
Do you ever have to push up on a bulge in the vaginal are with your fingers to start or complete urination? Y / N

Do you feel that you need to strain too hard to have a bowel movement? Y / N
Do you feel that you have not emptied you bowels at the end of a bowel movement? Y / N
Do you usually lose control of your stool? Y / N
Do you usually lose control of gas from the rectum? Y / N
Do you ever have pain when you pass your stool? Y / N

Are you currently sexual active? Y / N
Is sexual activity an important consideration in how we manage your problem? Y / N

GYN
Number of pregnancies:_____ Number of Vaginal births:_____ History of episiotomy/laceration: Y / N
When was your last menstrual period?_____
If you are still menstruating, are you periods:
Regular / Irregular Heavy / Average / Light Painful: Y / N
Are you having abnormal vaginal discharge or discomfort? Y / N

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Are you taking hormones (Estrogen/Progestin's)? Y / N

If yes, please list:

Hormonal replacement therapy_____

Oral contraceptive_____

Vaginal estrogen creams_____

When was you last Pap smear?_____

Have you had your uterus removed (Hysterectomy)? Y / N

Have you had you ovaries removed (Oophorectomy)? Y / N

QUATLITY OF LIFE IMPACT

How do your symptoms related to your urinary condition affect you ability to perform the following:

	Not at all	Minimal	Mild	Moderate	Severe
Household chores (cooking, cleaning, laundry)?	0	1	2	3	4
Physical recreation such as walking, swimming, other exercise?	0	1	2	3	4
Participate in activities (church, movies, concerts)?	0	1	2	3	4
Travel more than 30 minutes from home?	0	1	2	3	4
Participate in social activities outside your home?	0	1	2	3	4
Participate and enjoy sexual activity?	0	1	2	3	4