FLORIDA
UROGYNECOLOGY
SPECIALISTS

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Female Pelvic Medicine and Reconstructive Surgery
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HEALTH HISTORY INTAKE

Name (First, MI, Last): _____ DOB: _____

Referring Physician: _____

PHARMACY NAME: _____ Address/Intersection: _____ City: _____

HISTORY OF PRESENT ILLNESS

Which best describes your visit today? (May check more than one.) □ Prolapse □ Urinary Incontinence □ Incomplete Emptying
□ Urinary Urgency/Frequency □ Mesh Surgery Complication □ Bladder Pain □ Recurrent UTI □ Fecal Incontinence
□ Other: _____

Have you ever seen any other providers (physicians, physical therapists, etc) for this problem? If yes, please list the physician and any evaluation or therapy. _____

When did this problem start? _____

What have you tried for relief (pessary, medication, physical therapy)? _____

What makes the problem better? _____

Does anything worsen the problem? _____

How severe is the problem now? (mild) 1 2 3 4 5 6 7 8 9 10 (severe)

What activities (if any) have you limited because of your condition? (Ex. Exercise, sexual activity, travel) _____

SEE NEXT PAGE...

UROGYNECOLOGY HISTORY

Genitourinary

1. In a typical day, how many times do you urinate? (***frequency***) _____
2. In a typical night, how many times do you awaken to urinate?: (***nocturia***) _____
3. Do you leak urine when you do the following activities (***stress incontinence***)?: □ No □ Yes
   If yes, check any conditions that cause you to leak:
   3a. □ Coughing □ Sneezing □ Laughing □ Exercise □ Upon standing □ Housework □ Lifting □ Intercourse
4. In a typical day, do you experience frequent, strong urges to urinate?: (***urgency***) □ No □Yes
   4a. *If yes, do you leak urine during these strong urges: (**urge incontinence**)* □ No □Yes
5. In a typical week, do you have **difficulty emptying your bladder**? □ No □ Yes
6. Do you wear **pads**: □ No □ Yes
   6a. *If yes, how many pads do you wear per day?* _____
7. How much do you drink in a typical day? (***fluid intake***) _____
8. Please list any **overactive bladder medicines** you have tried and how long did you use them? _____

_____

Gastrointestinal

9. In a typical week, how many **bowel movements** do you have? _____
10. In a typical week, how many **laxatives** do you use? _____
11. In a typical week, do you have **difficulty having bowel movements**?: □ No □ Yes
12. In a typical week, do you **leak stool** when you do not want to?: (***fecal incontinence***) □No □ Yes
13. In a typical week, do you **leak gas** when you do not want to?: (***flatal incontinence***) □ No □ Yes

Gynecologic

14. Do you feel that your bladder, uterus, vagina or rectum are **falling out**?: (***prolapse)*** □ No □ Yes
15. Are you currently **sexually active**? □ No □ Yes
16. Do you have any **physical problems** with sexual relations? □ No □ Yes
17. Do you have **pain** with sexual intercourse? (***dyspareunia***) □ No □ Yes

MEDICAL/GYNECOLOGICAL

(Please check yes if applicable.)

_____ **HEART DISEASE**	_____ **LUPUS**	_____ **ABNORMAL PAP**
_____ **HEART ATTACK**	_____ **NEUROLOGIC DISORDER**	_____ **CERVICAL PROCEDURES**
_____ **HIGH BLOOD PRESSURE**	_____ **PSYCHIATRIC ILLNESS**	_____ **SEXUALLY TRANSMITTED INFECTIONS (STI)**
_____ **STROKE**	_____ **THYROID DISEASE**	_____ **BARTHOLIN'S CYST**
_____ **BLOOD CLOTS (DVT)**	_____ **CROHN'S**	_____ **FIBROIDS**
_____ **PULMONARY EMBOLISM**	_____ **IBS**	_____ **ENDOMETRIOSIS**
_____ **DIABETES MELLITUS**	_____ **HIV**	_____ **NARROW-ANGLE GLAUCOMA**
_____ **COPD**	_____ **HEPATITIS**	
_____ **ASTHMA**	_____ **OTHER (PLEASE SPECIFY):** _____	

If positive for **history of cancer,** please list area affected: _____ Radiation: □ Yes □ No

SURGICAL HISTORY

Pelvic Surgery

- □ Cesarean section: If yes, how many? _____
- □ Hysterectomy: What type? □ Abdominal □ Vaginal □ Laparoscopic/Robotic
  Reason for hysterectomy: _____
- □ Ovarian/Tubal surgery: □ Both ovaries were removed □ Right ovary □ Left ovary □ Both tubes □ Left tube □ Right tube
  Reason: _____
- □ Bladder or vaginal surgery (please list all)
  Reason: □ Prolapse □ Incontinence

Procedure:_____Surgeon/year:_____Facility:_____

Procedure:_____Surgeon/year:_____ Facility:_____

Procedure:_____Surgeon/year:_____ Facility:_____

Did any surgery use mesh? □Yes □No □Unsure

Other pelvic surgery? _____

Abdominal Surgery □ Appendix □ Gallbladder □ Bowel/colon □ Hernia

Orthopedic surgery □ Hip □ Knee □ Shoulder

Other surgery or hospitalization? (ex. UTI, SEPSIS, MOTOR VEHICLE ACCIDENT) _____

FAMILY HISTORY

Has anyone in your family had any of these diseases? If so, please give the relationship of the person to you.

1. Breast cancer: (ex. Mother) _____
2. Heart disease:_____
3. Ovarian cancer:_____
4. Colon cancer:_____
5. Prolapse (including cystocele or rectocele):_____
6. Urinary Incontinence:_____

Other disease(s)/family members, please list:_____

SOCIAL HISTORY

Occupation (or former occupation): _____ Hobbies: _____

Do you smoke currently? Did you smoke in the past?	□ No □ No	□Yes □Yes	If yes:_____# packs per day for_____years. Are you interested in quitting? □No □Yes
Do you drink alcohol?	□ No	□Yes	If yes, how much:_____

Do you use any street drugs?	□ No	□Yes	If yes, please explain:_____
Do you exercise?	□ No	□Yes	If yes, please describe:_____

OBSTETRIC HISTORY

Please list number of:

Pregnancies: _____ Miscarriages/Abortions: _____ Living Children: _____ Vaginal deliveries: _____

C-sections: _____ Multiple Births: _____ Weight of largest infant: _____

Were forceps or vacuum used? □ Yes □ No Any tears into rectum: □ Yes □ No

MENSTRUAL HISTORY

Age at first period: _____ First day of last menstrual period: _____ or Age at Menopause _____

Abnormal cycles: □Yes □No *If* yes, please explain _____

Postmenopausal bleeding? □Yes □No Currently have IUD? □Yes □No

CANCER SCREENING

Colon cancer:

Year of last colonoscopy: _____ *Results:* _____ *History of abnormal?* □*Yes* □*No*

Breast cancer:

Year of last mammogram: _____ *Results:* _____ *History of abnormal?* □*Yes* □*No*

Cervical cancer:

Year of last pap smear: _____ *Results:* _____ *History of abnormal?* □*Yes* □*No*

Other PHYSICIANS

PRIMARY CARE PROVIDER: _____ OB/GYN: _____

CARDIOLOGIST: _____ NEUROLOGIST: _____

PULMONOLOGIST: _____ PAIN MANAGEMENT: _____

RHEUMATOLOGIST: _____ ENDOCRINOLOGIST: _____

ONCOLOGIST: _____ UROLOGIST: _____

GASTROENTEROLOGIST: _____ COLORECTAL: _____

ALLERGIES

*May continue list on back of handout as needed. *

Allergies? □**YES** □ **NO** If yes, please list your allergies and reactions below (medications, foods, environmental, latex)

ALLERGY *(EX. LATEX)*	**REACTION** *(EX. HIVES , HEAD TO TOE)*

MEDICATIONS

Please list (PRESCRIPTIONS, BLOOD THINNERS, OVER-THE-COUNTER, HORMONES, BIRTH CONTROL IMPLANTS OR IUDs, OR WHETHER A VITAMIN OR SUPPLEMENT)

*May continue list on back of handout as needed. *

MEDICATION	**DOSAGE**	**QUANTITY USED**	**TIMES PER DAY**	**ROUTE** (EX. ORAL, SUBLINGUAL, SUBCUTANEOUS, INTRAMUSCULAR, TOPICAL, IINTRAVENOUS, INSERTED, IMPLANTED, INHALATION)
(EX. COUMADIN)	*1 MG*	*1 TABLET*	*ONCE DAILY*	*ORALLY*

Thank you for completing these forms. This enables us to serve you completely.