Tampa Location:
2919 W. Swann Ave. Suite 404
Tampa, Fl 33609
Phone: (813)773-0579
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Lakewood Ranch Location:
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Bradenton, Fl 34203
Phone : (941)241-0161
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Female Pelvic Medicine and Reconstructive Surgery/ Urogynecology

HEALTH HISTORY INTAKE

Name (First, MI, Last): ____ DOB: _____________________

Primary Care Physician: _______________________________________ Phone:_____________________ Fax: ______________________

Referring Physician: ____ Phone:_____________________ Fax: ______________________

Pharmacy Name: __________________________ Pharmacy Phone: ____________________________ Street Address: _________________

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
   - 3a. If yes, check any conditions that cause you to leak:
   - ☐ 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 many UTI's have you had in the last 6 months? ______
   - 7a. Were they culture confirmed? ☐ No ☐ Yes
   - 7b. How were they treated? ____
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

☐ Hysterectomy: Year_________ 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 hospitalizations? (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*

CANCER SCREENING HISTORY

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*

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.