Medical History Form – Institute of Female Pelvic Medicine

Name:	DOB: / /	Date:

Special assistance needed for care	☐ None ☐ Lifting Assistance ☐ Wheelchair Accessibility ☐ Interpreter ☐ Other_____

Please describe the reason for your visit:

CURRENT MEDICATIONS: List all current prescriptions and over-the-counter medications including dose and frequency

ALLERGIES:

☐ No Known Allergies	☐ Adhesive Tape	☐ Cephalosporins	☐ Codeine	☐ Erythromycin
☐ Iodine	☐ Latex	☐ Lidocaine	☐ Demerol	☐ Morphine
☐ NSAIDS (Advil, Aleve)	☐ Penicillin	☐ Salicylates	☐ Succinimides	☐ Sulfa
☐ Tetracyclines	☐ Pertussis Vaccine	☐ Other _____		
Food Allergies:	☐ None	☐ Eggs	☐ Dairy	☐ Nuts
	☐ Shellfish	☐ Gluten	☐ Other _____	

MEDICAL HISTORY: (Select all that apply)

☐ None	☐ Anemia	☐ Anxiety	☐ Arthritis	☐ Asthma
☐ Autoimmune Disorder	☐ Blood/Clotting Disorder	☐ Blood Transfusion	☐ Colon Cancer	☐ Depression
☐ DES Exposure	☐ Diabetes	☐ DVT/PE (blood clot in leg/Lungs	☐ Eating Disorder	☐ Fracture
☐ GERD/Acid Reflux	☐ Gallbladder Disease	☐ GI Issues (bowel trouble/IBS)	☐ Glaucoma	☐ Heart Disease
☐ Hepatitis/Liver Disease	☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease	☐ Kidney Stones
☐ Lung Problems	☐ Migraine Headaches	☐ Mitral Valve Prolapse	☐ Osteoporosis	☐ Rectal Cancer
☐ Seizures	☐ Substance Abuse	☐ Stroke	☐ Thyroid Disease	☐ Vision or Hearing Impairment
☐ Other _____				

GYN HISTORY: (Select all that apply)

☐ None	☐ Breast problems	☐ Endometriosis	☐ Fibroids	☐ Pelvic inflammatory disease
☐ Polycystic Ovarian Syndrome (PCOS)	☐ Breast Cancer	☐ Cervical Cancer	☐ Endometrial Cancer	☐ Ovarian Cancer
☐Uterine Cancer	☐ Other _____			

SURGICAL HISTORY: (Select all that apply)

☐ None	☐ Appendectomy	☐ Back Surgery	☐ Breast Augmentation	☐ Breast Biopsy
☐ Breast Reduction	☐ Breast Surgery	☐ D&C	☐ Hysteroscopy	☐ Foot Surgery
☐ Gallbladder Removal	☐ Hip Surgery	☐ Knee Surgery	☐ Oral Surgery	☐ Shoulder Surgery
☐ Thyroid Surgery	☐ Tonsillectomy	☐ Bilateral Tubal ligation	☐ Hysterectomy	☐ Ovaries Removed
☐ Laparoscope	☐ Uterine Ablation	☐ C-Section	☐ Other_____	

HEALTH MAINTENANCE: answer all that apply with Date and Results

Last Pap Smear				
Last HPV Test				
History of abnormal pap If yes, indicate treatment	☐ None ☐ No treatment	☐ Yes ☐ Freezing	☐ LEEP/cone	☐ Laser
Last Routine Screening Labs				
Last Mammogram				
Last Colonoscopy				

MENSTRUAL HISTORY – If you ARE having menstrual cycles, please answer the following. Otherwise, skip to next section	
At what age did your periods start	
What was the first day of your last period	
What is the length of time between periods	☐ Irregular ☐ 21-32 days ☐ less than 21 days ☐ 33-44 days ☐ more than 45 days
How long does your period last	☐ 2-7 days ☐ longer than 7 days
How would you describe your flow	☐ Light ☐ Moderate ☐ Heavy
Do you have pain/cramping associated with your periods	☐ No pain/cramping ☐ Mild discomfort ☐ Moderate discomfort ☐ Severe pain/cramping
Any other symptoms associated with your period	☐ None ☐ Headaches ☐ Bloating ☐ Irritability ☐ Migraines ☐ Weight Gain ☐ Mood swings ☐ Nausea ☐ Bowel issues
MENSTRUAL HISTORY – If you ARE NOT having menstrual cycles, please answer the following.	
Reason for no menses	☐ Menopausal ☐ Pregnant/Breastfeeding ☐ IUD in place ☐ Hysterectomy ☐ Unknown
Menopausal - What age did this occur	
Menopausal - Any current menopausal symptoms	☐ None ☐ Hot Flashes/Night Sweats ☐ Memory Loss ☐ Headaches ☐ Irritability ☐ Weight gain ☐ Decrease Libido ☐ Vaginal Dryness
Menopausal - Are you taking any treatments	☐ None ☐ Hormones ☐ OTC treatments
IUD - What type is in place	☐ Mirena ☐ Liletta ☐ Kyleena ☐ Skyla ☐ Paragard ☐ Unknown
IUD – When was it placed	
SEXUAL HISTORY	
Have you ever been sexually active	☐ Yes ☐ No (Skip to next section)
Are you currently sexually active	☐ Yes ☐ No
Age of first sexual encounter	
Have you had more than 5 lifetime partners	☐ Yes ☐ No
Type of birth control	☐ Nothing ☐ Withdrawal ☐ Condoms ☐ Diaphragm ☐ Spermicide ☐ Oral Contraceptives ☐ Contraceptive Patch ☐ Contraceptive Vaginal Ring ☐ Depo Provera ☐ Nexplanon ☐ IUD ☐ Tubal ligation ☐ Vasectomy ☐ Hysterectomy
Have you ever been diagnosed with a Sexually Transmitted Infection (STI)	☐ None ☐ Human Papilloma Virus (HPV) ☐ Chlamydia ☐ Herpes Simplex Virus (HSV) ☐ Gonorrhea ☐ Syphilis ☐ Trichomoniasis ☐ Hepatitis B ☐ Hepatitis C ☐ Human Immunodeficiency Virus (HIV)

OB HISTORY			
Total # of Pregnancies		Total living children	
# of full-term pregnancies (37 weeks or greater)		# of preterm pregnancies (less than 37 weeks)	
# of miscarriages/abortions		# of ectopic (tubal) pregnancies	
# of vaginal deliveries		# of Cesarean deliveries	
Largest Baby Weight		Forceps or Vacuum	☐ Yes ☐ No
Episiotomy	☐ Yes ☐ No	Laceration/Tear	☐ Yes ☐ No
Degree of tear/Details			
Comments and complications:			

FAMILY HISTORY: Please check all that apply ☐ Family history unknown/adopted

Medical Condition	Mother	Father	Sibling	Child	Mat GM	Mat GF	Pat GM	Pat GF
Bleeding Disorder								
Heart Disease								
Diabetes								
Hypertension								
Breast Cancer								
Ovarian Cancer								
Colon Cancer								
Uterine Cancer								
Stroke								
Thyroid Disorder								
Osteoporosis								

Patient Name _____ Date of Birth_____

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Auto Immune Disorders								
Mental Illness								
Other								

SOCIAL HISTORY	
Tobacco/Smoking	
Do you now or have you ever smoked or used tobacco products?	☐ Yes ☐ No (Skip to next section)
Age you started smoking	
Type of Product	☐ Cigarettes ☐ e-cigarette ☐ Vape ☐ Chewing tobacco
Amount of Use	☐ Daily ☐ Some days but not every day ☐ 5 or less/day ☐ 6-10/day ☐ 11-20/day ☐ 21-30/day ☐ more than 31/day
Former Smoker – Age you stopped	
Alcohol	
Have you had a drink containing alcohol in the last year?	☐ Yes ☐ No (Skip to next section)
How often did you have a drink containing alcohol in the last year	☐ Less than monthly ☐ 2-4 times per month ☐ 2-3 times per week ☐ 4 or more times per week
Recreational Drugs	
Have you ever used any recreational drugs	☐ Yes ☐ No (Skip to next section)
Type of Use	☐ Marijuana ☐ Heroin ☐ Cocaine ☐ Crack ☐ Methamphetamine ☐ Opiates ☐ Ecstasy ☐ LSD ☐ PCP ☐ Ketamine ☐ Other _____
How long since you last used	
How often do you use	
Are you interested in a treatment program	☐ Yes ☐ No ☐ Unsure
Other	
Would you object to blood products in the event of an emergency?	☐ Yes ☐ No

Review of Systems: Please indicate if you have had or currently have any of the following						
Constitutional: Weight change	☐ Yes ☐ No	Fatigue	☐ Yes ☐ No		
Eyes: Visions changes	☐ Yes ☐ No	Cataracts	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Ears/Nose/Mouth/Throat: Ulcers	☐ Yes ☐ No	URI (upper respiratory infection	☐ Yes ☐ No		
Cardiovascular: Heart Conditions	☐ Yes ☐ No	Orthopnea (difficulty breathing while lying down)	☐ Yes ☐ No	DOE (difficulty breathing on exertion)	☐ Yes ☐ No
Respiratory: Shortness of Breath	☐ Yes ☐ No	Wheezing	☐ Yes ☐ No		
Gastrointestinal: Nausea/Vomiting	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No	Bloody Stool	☐ Yes ☐ No
Musculoskeletal: Weakness	☐ Yes ☐ No				
Skin: Rash	☐ Yes ☐ No				
Neurologic: Seizures	☐ Yes ☐ No	Syncope (fainting)	☐ Yes ☐ No	Neuropathy	☐ Yes ☐ No
Psychiatric: Depression	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No		
Endocrine: Hot flashes	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Thyroid	☐ Yes ☐ No
Hematologic: Easy bruising	☐ Yes ☐ No	Bleeding	☐ Yes ☐ No	Adenopathy (swollen glands)	☐ Yes ☐ No
Allergic: Seasonal	☐ Yes ☐ No	Animal Dander/Foods	☐ Yes ☐ No		
Other:					

Patient Name _____ Date of Birth_____

Reviewed by _____ on _____

Pelvic Floor Distress Inventory

Please answer each question by checking the best response. While answering these questions, please consider your symptoms over the last 3 months. We realize that you may not be having problems in some of these areas but please fill out all forms as completely as possible.

Urinary Distress Inventory 6 (UDI-6)

Do you experience, and, if so, how much are you bothered by…….	Not at all	Somewhat	Moderately	Quite a bit
Frequent urination				
Urine leakage associated with a feeling of urgency (a strong sensation of needing to go to the bathroom)				
Urine leakage related to coughing, sneezing, or laughing				
Small amounts of urine leakage (drops)				
Difficulty emptying your bladder				
Pain or discomfort in the lower abdomen or genital region				

Colorectal-Anal Distress Inventory 8 (CRADI-8)

Do you experience, and, if so, how much are you bothered by…….	Not at all	Somewhat	Moderately	Quite a bit
Feel you need to strain too hard to have a bowel movement				
Feel you have not completely emptied your bowel at the end of a bowel movement				
Lose stool beyond your control if your stool is well formed				
Lose stool beyond your control if your stool is loose				
Lose gas from rectum beyond your control				
Pain when you pass your stool				
A strong sense of urgency and have to rush to the bathroom to have a bowel movement				
Part of your bowel passing through the rectum and bulge outside during or after a bowel movement				

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)

Do you experience, and, if so, how much are you bothered by…….	Not at all	Somewhat	Moderately	Quite a bit
Pressure in the lower abdomen				
Heaviness or dullness in the pelvic area				
A bulge or something falling out that you can see or feel in your vaginal area				
The need to push on the vagina or around the rectum to have or complete a bowel movement				
A feeling of incomplete bladder emptying				
The need to push up on the bulge in the vaginal area with your fingers to start or complete urination				

Patient Name _____ Date of Birth_____

Reviewed by _____ on _____

Pelvic Floor Impact Questionnaire

Instructions: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feelin0gs. 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 relate to the following →→→ Usually affect your ↓	Bladder or Urine	Bowel or Rectum	Vagina or Pelvis
1. Ability to do household chores (cooking, house cleaning, 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 exercise?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
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 of 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

Patient Name _____ Date of Birth_____

Reviewed by _____ on _____

Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire

Instructions: Following are a list of questions bout 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 life. Please check the box that best answers the questions for you. While answering the questions, consider your sexuality over the past **6 months.** Thank you for your help.

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.
   ☐ Daily ☐ Weekly ☐ Monthly ☐ Less than Once a Month ☐ 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 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

10. Does your partner have a problem with <u>erections</u> that affects your sexual activity?
    ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

11. Does your partner have a problem with premature ejaculation that affects your sexual activity?
    ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

12. Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?
    ☐ Much less intense ☐ Less intense ☐ Same intensity ☐ More intense ☐ Much more intense

13. Does your prolapse or incontinence decrease your partners desire to have sexual relations?
    ☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

Patient Name _____ Date of Birth_____
Reviewed by _____ on _____