Advanced Urogynecologic Care- Intake Questionnaire:

Name: ______________________ **Date of Birth:** _______________ **Height:** ________ **Weight:** ________**lbs**

Your Primary Care Physician (Location): Name ____

What problem are you here for today? ____

MEDICATIONS:
Please list any medications **changes:** (including hormones, contraceptives, vitamins)

____
____
____
____
____

ALLERGIES:
Do you have any **new** drug allergies? ◻ Yes ◻ No
Please list which drugs you are allergic to and what happens when you take them:
____

Please list any **new** medical problems or surgeries since the last visit:

____
____
____

How often are you urinating (# hours between daytime voids)?

◻ Less than 1 hour
◻ Every 1 -2 hours
◻ Every 3-4 hours
◻ Every 4-5 hours
◻ more than 5 hours

How many times do you wake at night to urinate?

◻ 0
◻ 1
◻ 2
◻ 3
◻ 4
◻ 5
◻ More than 5 times

How often do you leak urine?

◻ Never
◻ About once a week or less often
◻ 2-3 times a week
◻ About once a day
◻ Several times a day
◻ All the time

How much urine do you usually leak? (Whether you wear protection or not)

◻ None
◻ A small amount
◻ A moderate amount
◻ A large amount

Turn Over →

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Overall, how much does leaking urine interfere with your everyday life? Please circle a number between 0 (not at all) and 10 (a great deal):

0 1 2 3 4 5 6 7 8 9 10

Not at all *A great deal*

When does the urine leak? (Please check all that apply)

- □ Never – urine does not leak
- □ Leaks before you can get to the toilet
- □ Leaks when you cough or sneeze
- □ Leaks when you are asleep
- □ Leaks when you are physically active / exercising
- □ Leaks when you stand up after urinating
- □ Leaks for no obvious reason
- □ Leaks all the time

GENERAL REVIEW OF SYMPTOMS: Please check if you've recently had any of the following:

□Fever or chills	□ Shortness of breath	□ Rashes
□ Headache	□ Heartburn	□ Loss of balance
□ Blurred vision	□ Blood in Stool	□ Anxiety
□ Chest pain	□ Muscle aches/pain	
□ Easy bruising/bleeding	□ UTI symptoms	
□ Vaginal bleeding	□ Blood in urine	

For Medical Assistant ONLY

→ □Flowsheets □Med Hx □Meds/Allergies □PVR/Dip □Consent □Vitals

Turn Over →