Advanced Urogynecologic Care - Intake Questionnaire:

Name: _____ Date of Birth: _____ Height: _____ Weight: _____

Preferred Pharmacy: Name _____ City/Zip _____

Your Primary Care Physician:
Name: _____
Phone/Fax:_____
Location: _____

Your Gynecologist:
Name: _____
Phone/Fax: _____
Location: _____

Which of the above physicians referred you to our office? _____

Prior patient of Dr. Tomezsko? □Yes □ No

What problem are you here for today? _____

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

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

MEDICAL HISTORY:
As an adult have you had any of the following (check all that apply)?

- o Glaucoma
- o High Blood Pressure
- o Heart Disease
- o High Cholesterol
- o Blood Clots/ Bleeding disorders
- o Lung Problems
- o Liver Disease
- o GERD/Reflux
- o Bowel Incontinence
- o Constipation
- o Irritable Bowel Syndrome (IBS)
- o Blood in the urine
- o Bladder Infections
- o Interstitial Cystitis
- o Kidney Disease
- o Kidney or Bladder Stones
- o Back Problems/ Spinal stenosis
- o Arthritis
- o Fibromyalgia
- o Breast Cancer
- o Stroke
- o Dementia
- o Sleep Apnea
- o Multiple Sclerosis
- o Parkinson's Disease
- o Anxiety/Depression
- o Diabetes
- o Hypothyroid
- o Pelvic Pain
- o Fibroids
- o Abnormal Pap Smear
- o Endometriosis
- o Painful Periods
- o Postmenopausal Bleeding
- o Other Cancer _____

Any other medical conditions not listed above? Please list here: _____
_____
_____

SURGICAL HISTORY

If you are over the age of 45, have you had a colonoscopy in the past 5 years?
□ Yes
□No

Have you had a Hysterectomy?
□Yes
□ No
If yes: which hospital and when? _____
For what reason? (*e.g., "fibroids, bleeding, prolapse"*): _____
What type?
□Vaginal Hysterectomy
□Abdominal Hysterectomy
□Laparoscopic or Robotic Hysterectomy

Have you had your ovaries removed?
□Yes
□ No

Have you had previous surgery for urinary incontinence?
□Yes
□ No
If yes: which hospital and when? _____ _____
What type?
□Sling procedure
□Needle Suspension
□Burch of MMK
□Urethral Injection

Have you had any previous surgery for pelvic relaxation/prolapse?
□Yes
□ No
If so: which and when? _____
What type?
□Vaginal incision
□Abdominal incision
□ Laparoscopic or robotic

List and other operations or surgeries, and the year performed:

OBSTETRICAL HISTORY

Number of Pregnancies_____
Number of Live Births_____
Number of Vaginal Deliveries_____
Number of Cesarean Sections_____

FAMILY & SOCIAL HISTORY

Have any first-degree relatives had these diseases? If so, please indication their relationship
Ovarian Cancer: _____
Breast Cancer: _____
Other Cancer (list type): _____
Heart Disease: _____
Kidney Disease: _____
Blood/ Clotting Disorder: _____
Other Family Diseases: _____

Do you smoke?
□Yes
□ No
□ Prior smoker

Do you drink alcohol?
□Yes → Type: _____ How often? _____
□ No

Are you sexually active?
□Yes
□ No

Are you currently married?
□Yes
□ No

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

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

Please list the ONE symptom that is MOST bothersome:

_____

Which of the following symptoms are bothering you? Check all that apply:

Urinary
□ Urinary Incontinence
□ Frequent Urination
□ Nighttime voiding
□ Urgency to urinate
□Urinary or Bladder burning/pain
□ Frequent Bladder infections
□ Difficulty emptying bladder
□ Blood in the urine

Vaginal
□ Vaginal/ Uterine prolapse (buldge)
□ Vaginal or vulvar pain
□ Vaginal bleeding
□ Vaginal discharge
□Vaginal dryness
□ Vaginal or vulvar itching

Bowel
□ Accidents involving stool
□ Accidents involving gas
□ Constipation

Other
□ Pelvic Pain

Other problem not listed above: _____
_____
_____

How long have these problems been present?
□ Less than 1 month
□ 1-6 months
□ 6-12 months
□ 1-2 years
□ 3-5 years
□ 6-10 years
□ More than 10 years

Have you had any prior treatments for these problem(s)?
□ No prior treatments
□ Overactive Bladder medication
□ Antibiotics for frequent bladder infections
□ Kegel exercises
□ Physical therapy for the pelvic floor
□ Vaginal Estrogen Therapy
□ Surgery for urinary incontinence
□ Surgery for prolapse (vaginal bulge)
□ Medication for pelvic or vaginal pain
□ Pessary
□Stool Softeners
□ Laxatives
□ Botox (for bladder or pelvic symptoms)
□ Interstim (“bladder pacemaker”)
□ Acupuncture (bladder or pelvic symptoms)
□ Urethral injections
□ Bladder Instillations (medicine put into the bladder
□ Other: _____

What are your goals in seeking our help (check all that apply)?

□ Improve my bladder control
□ Decrease daytime urination
□ Decrease nighttime urination
□ Reduce urinary (bladder) infections
□ Fix my prolapse (vaginal "bulge")
□ Reduce my vaginal prolapse symptoms
□ Improve my bowel control
□ Reduce constipation and difficulty having BM's
□ Improve sexual function
□ Reduce pain in pelvis, bladder, vagina
□ Other: _____

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

During an average day, how many pads or diapers do you use?

□ 0
□ 1-2
□ 3-4
□ >5

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

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

Check the one category that best describes how your urinary symptoms are now:

□ Normal

□ Mild

□ Moderate

□ Severe

For Medical Assistant ONLY

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