PELVIC HEALTH NEW PATIENT FORM

Please list the problems you would like evaluated today: *(circle what bothers you most)*

How long have you had THIS problem?

Have you been evaluated for THIS problem before today’s visit?  □ No  □ Yes

*If yes, check all that apply*  □ Colorectal Surgeon  □ Gastroenterologist  □ Urogynecologist

 □ Urologist  □ Other specialist(s): __________________

PREVIOUS DIAGNOSTIC STUDIES *(Please check all applicable boxes)*

□ CT Scan  □ Anorectal manometry  □ Cystoscopy *(look in bladder with scope)*

□ Kidney Ultrasound  □ Barium enema  □ Urodynamic test *(bladder function test with catheter)*

□ Pelvic Ultrasound  □ Colonoscopy  □ Other:

□ MRI  □ Defecography

PAST MEDICAL HISTORY *(Please check all that apply, now or in the past)*

□ I have no medical problems

□ Anxiety  □ Dementia *(i.e. Alzheimer’s)*  □ Kidney Failure

□ Asthma  □ Diabetes, type: ______________  □ Kidney stones

□ Blood Clots  □ Gastrointestinal Ulcers  □ Liver Disease/Hepatitis

□ Cancer:____________  □ Heart Attack/Chest Pain  □ Psychiatric Disease

□ COPD  □ Heart Valve/Rhythm Problem  □ Stroke/TIA

□ Chronic back pain +/- Neuropathy  □ Immune Disorder *(specify): ________________

□ Depression  □ High Blood Pressure  □ Thyroid Disease

□ Other significant medical problems, hospitalizations, or trauma *(specify): __________________
LIST CURRENT MEDICATIONS  (Attach list if available)

- No Medications
- I reviewed my medication list on MyHealth/EPIC

MEDICATION ALLERGIES  (Please list below)

- None
- I reviewed list on MyHealth/EPIC

SURGICAL HISTORY

- I have had no surgeries

<table>
<thead>
<tr>
<th>Operation</th>
<th>Month/Year</th>
<th>Reason for Surgery</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

FAMILY HISTORY (i.e. Cancer, Frequent UTIs, Kidney Stones, Prolapse, Heart Attack before age 60)

- I have no family history of medical problems

SOCIAL HISTORY

Do you use any tobacco?  (Check all that apply)

- Never smoked
- No, I quit  When? ________  #packs/day? ________  How many years (estimate)? ________
- Yes, I smoke tobacco  #packs/day? ________  How many years (estimate)? ________

Do you drink alcohol?  

- Yes
- No  If yes, how many drinks per week/month/year? ________

Do you use recreational drugs?  (i.e. marijuana, cocaine, heroin, methamphetamines, etc.)

- Yes
- No  If yes:  What type? __________________________  How often? __________________________

MARITAL STATUS:

- Single
- Married
- Divorced
- Widowed
- Other ____________

OCCUPATION:  (current or most recent): __________________________

Have you ever been sexually abused, threatened, or hurt by anyone?

- Yes, in the past
- Yes, currently
- No
### GASTROINTESTINAL HISTORY

During the past 12 months, what do your bowel movements usually look like when you are not taking laxatives? *(please circle)*

<table>
<thead>
<tr>
<th>BRISTOL STOOL CHART</th>
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</thead>
<tbody>
<tr>
<td><strong>Type 1</strong></td>
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<tr>
<td><strong>Type 2</strong></td>
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<td><strong>Type 3</strong></td>
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<td><strong>Type 4</strong></td>
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<td><strong>Type 5</strong></td>
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<td><strong>Type 6</strong></td>
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<tr>
<td><strong>Type 7</strong></td>
</tr>
</tbody>
</table>

During a typical 2-week period, how many times do you usually have a bowel movement?

- _____ 1 or more/day
- _____ 2 or fewer times/day
- _____ Less than once/week
- _____ Less than once/2 weeks

Do you have rectal bleeding?

- [ ] Yes
- [ ] No
Please complete if you have any **BOWEL PROBLEMS** (Otherwise, skip to next page)

**Accidental Bowel Leakage: Unable to control the bowel**

For each of the following, please indicate on average how often in the past month you experienced any amount of **accidental bowel leakage**: (Check only 1 box per row)

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Less than once a month</th>
<th>Greater than once a month and less than once a week</th>
<th>Greater than once a week and less than daily</th>
<th>Daily or several times a day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gas</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Liquid Stool</td>
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<tr>
<td>Solid Stool</td>
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<tr>
<td>Do you wear a pad?</td>
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<tr>
<td>Does bowel leakage impact your quality of life?</td>
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</tbody>
</table>

**Difficult Evacuation: Difficulty emptying the bowels**

Do you have difficulty emptying the bowels? (Check only 1 box per row)

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excessive Straining</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Incomplete rectal sensation</td>
<td></td>
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<tr>
<td>Use of enema/laxatives</td>
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<tr>
<td>Do you need to use a finger to help evacuate stool</td>
<td></td>
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<tr>
<td>Abdominal discomfort /pain</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
URINARY HISTORY

Please complete if you have any **URINARY PROBLEMS** *(Otherwise, skip to next page)*

Do you drink any of the following fluids? *(please check all that apply and give your best estimate)*

- ☐ Caffeine (i.e. coffee, tea, soda, energy drinks)  How many cups/day: __________
- ☐ Carbonated fluids (i.e. sparkling water, caffeine free soda)  How many cups/day: __________
- ☐ Water (uncarbonated)  How many cups/day: __________
- ☐ Other (please list): __________________________  How many cups/day: __________

Do you take any medications for an overactive bladder?  ☐ Yes  ☐ Yes, but I stopped taking it  ☐ No

*CIRCLE* all that apply:  Oxybutynin, Trospium, Detrol, Vesicare, Mirabegron, Enablex, Toviaz

Other: __________________________________________________________

Do you go to the bathroom to urinate too frequently?

- ☐ Yes  ☐ Yes, but it doesn’t bother me  ☐ No

If yes, how frequently (i.e. every 1, 2, 3 hours): ______  How many times during the day? ______

Do you get sudden urges to urinate and have to drop everything and run?

- ☐ Yes  ☐ Yes, but it doesn’t bother me  ☐ No

If yes, how frequently does this happen *(circle one)*:

rarely  daily  weekly  monthly  other: ________

Do you leak because you can’t make it to the bathroom?

- ☐ Yes  ☐ Yes, but it doesn’t bother me  ☐ No

If yes, how frequently does this happen *(circle one)*:

rarely  daily  weekly  monthly  other: ________

Do you leak when you cough, sneeze, laugh, or exercise?

- ☐ Yes  ☐ Yes, but it doesn’t bother me  ☐ No

If yes, how frequently does this happen *(circle one)*:

rarely  daily  weekly  monthly  other: ________
URINARY HISTORY (continued)

Do you wear pads (or diapers) for urinary leakage?
☐ Yes  ☐ Yes, but it doesn’t bother me  ☐ No  If yes, how many per day? _______

Do you get up at night to urinate (nocturia)?
☐ Yes  ☐ Yes, but it doesn’t bother me  ☐ No  If yes, how many times per night? _______

Do you leak or wet the bed while sleeping at night?
☐ Yes  ☐ No
If yes, how frequently does this happen (circle one):
- rarely
- daily
- weekly
- monthly
- other: _______

Do you have difficulty emptying your bladder?
☐ Yes  ☐ No  ☐ Sometimes  If yes, explain: __________________________________________

Do you have any of the following? (If yes, please check all that apply)
☐ Burning with urination  ☐ Visible blood in urine  ☐ No, I do not experience any of these

Do you have Recurrent Urinary Tract Infections (UTIs)?  ☐ Yes  ☐ No
(If yes, please answer the following questions, otherwise skip to next page)

How OFTEN do you get UTIs (how many per year)? __________________________________________

How long has this been a problem (how many months or years)? __________________________________________

Please check all that apply:

☐ I get urine cultures sometimes  ☐ I always get urine cultures, they are usually positive

☐ I just get antibiotics when I have UTI symptoms  ☐ I always get urine cultures, they are usually negative

What are your UTI symptoms (please list all)? __________________________________________

What are your UTI triggers (i.e. sexual activity)? __________________________________________

What makes your UTIs better? __________________________________________
GYNECOLOGICAL HISTORY

Please complete if you are **FEMALE** *(Otherwise, skip to next page)*

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Sometimes</th>
<th>Sometimes, but it doesn’t bother me</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you sexually active?</td>
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<tr>
<td>Do you have pain with sex?</td>
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<tr>
<td>Do you have abnormal vaginal bleeding? * (Bleeding between periods or after menopause)</td>
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<tr>
<td>Do you feel a bulge or pressure in the vagina?</td>
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</tbody>
</table>

**Number of pregnancies _____**  **Number of vaginal deliveries _____**  **Number of C-sections _____**

Were forceps or a vacuum used for any of your deliveries?  ❑ Yes  ❑ No  ❑ Not applicable

**When was your last menstrual period** *(or age at your last period)*? ________________

*Note: If you are post-menopause or hysterectomy (uterus removed), please give estimated age at last menstrual period.*

Are your periods regular?  ❑ Yes  ❑ No  ❑ Not applicable (i.e. menopause, hysterectomy)

Are you currently on any of the following?  ❑ No  ❑ Yes *(If yes, please check all that apply)*

- [ ] Cranberry pills
- [ ] Birth control pills/patch/ring/shots
- [ ] D-mannose powder
- [ ] Hormone replacement pills/patch (i.e. estrogen, progesterone)
- [ ] Low dose antibiotics
- [ ] Intrauterine Device (IUD) (i.e. Copper, Mirena)
- [ ] Probiotics
- [ ] Vaginal estrogen (i.e. Premarin, Vagifem, Estrace, or Estring)

Have you had a Pap smear?  ❑ Yes, all tests have been negative  ❑ Yes, I have had abnormal test(s)  ❑ No, never

*If yes, when was your last Pap smear (year)? ________________*

Have you had treatment for prolapse or incontinence?  ❑ Yes  ❑ No

*If yes, check all that apply:*

- [ ] Pessary
- [ ] Physical Therapy
- [ ] Prolapse Surgery
- [ ] Incontinence Surgery
- [ ] Other: ________________

15-3171 (10/18)
Please complete if you are **MALE** *(Otherwise, skip to next page)*

**Do you have difficulty emptying your bladder?** *(If yes, check all that apply)*  
- [ ] Yes  
- [ ] No

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ I feel that my bladder never or rarely gets empty</td>
<td>☐ I have a weak stream all or most of the time</td>
</tr>
<tr>
<td>☐ I have to go back to the bathroom right after urinating</td>
<td>☐ I always have to strain to urinate</td>
</tr>
<tr>
<td>☐ I drip after I am finished urinating and walk away</td>
<td>☐ It takes a while to get started</td>
</tr>
<tr>
<td>☐ I've had a catheter before because I couldn't urinate</td>
<td>☐ My stream is stop and go</td>
</tr>
</tbody>
</table>

| ☐ I had surgery to treat a urethral stricture (i.e. dilation, laser etc.) |

**Do you have problems with erections?**  
- [ ] No  
- [ ] Yes

*If yes, have you tried medications in the past?*  
- [ ] Yes  
- [ ] No  
- [ ] No, but I would like to try one

**Do you take any of the following medications?**  
- [ ] No  
- [ ] Yes  
- [ ] Yes, but I stopped taking it

*If yes, please check all that apply*  
- Tamsulosin (Flomax)  
- Dutasteride (Avodart)  
- Viagra  
- Alfuzosin (Uroxatral)  
- Proscar (Finasteride)  
- Cialis  
- Terazosin (Hytrin)  
- Dutasteride/Tamsulosin (Jalyn)  
- Levitra  
- Doxazosin(Cardura)  
- Testosterone replacement therapy  
- Levitra  
- Sildosin (Rapaflo)  
- Other prostate/male health medications: _________

**Have you had a Prostate Specific Antigen (PSA) – prostate cancer screening test?**  
- [ ] Yes, all have been normal  
- [ ] Yes, they have been elevated  
- [ ] No, never

*If yes, what was your last score (estimate is okay)?* _________ (month/year)

**Do any of the following apply to you?**  
- [ ] No  
- [ ] Yes  

*If yes, please check all that apply*  
- I had surgery to treat an enlarged prostate (i.e. TURP- Transurethral resection of prostate)  
- I had a prostate biopsy in the past  
- I have a family history of prostate cancer  
- I have a personal history of prostate cancer  

*If yes, what treatment did you receive?* _________
CURRENT REVIEW OF SYSTEMS

Have you had any problems **in this past year**? Check Yes or No and **explain Yes answers**. 
(Patients will be writing their comments on the form)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergic/Immunologic (rashes/infections/etc)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constitutional (general health, weight, energy)</td>
<td></td>
<td></td>
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<tr>
<td>Cardiovascular (heart/blood vessels/circulation)</td>
<td></td>
<td></td>
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<tr>
<td>Eyes (any visual problems)</td>
<td></td>
<td></td>
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<tr>
<td>Ears/Nose/Mouth/Throat (hearing/infections/congestion/pain)</td>
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<td></td>
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<tr>
<td>Endocrine (hormones/metabolism/thyroid)</td>
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<tr>
<td>Gastrointestinal (stomach/intestines/bowel movements)</td>
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</tr>
<tr>
<td>Hematologic/Lymphatic (bleeding/lymph nodes/swollen glands)</td>
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<td></td>
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<tr>
<td>Musculoskeletal (bones/joints/muscles)</td>
<td></td>
<td></td>
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<tr>
<td>Neurological (brain/nervous system)</td>
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<td></td>
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<tr>
<td>Psychiatric (emotions/mood/memory)</td>
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<td></td>
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<tr>
<td>Respiratory (lungs/breathing)</td>
<td></td>
<td></td>
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<tr>
<td>Integumentary (skin lesions/breast lumps)</td>
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<td></td>
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<tr>
<td>Genitourinary (genitals/sexual function/kidneys/bladder)</td>
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**PATIENT COMMENTS**

*By signing below, you are verifying that this form was completed to the best of your ability and knowledge.*

DATE    TIME    SIGNATURE (Patient /Legal Designated Representative)

PRINT NAME 15-3171 (10/18)    RELATIONSHIP TO PATIENT
Instructions to Attending Physician:

Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent or key finding(s) with the patient and/or family. Key finding(s) must be summarized in your progress note, however, the questionnaire may be referenced for additional details.

Attending Physician Signature  Print Name  Date  Time

The preceding information was also reviewed by:

Date  Time  Provider Signature/Title  Print Name

Date  Time  Provider Signature/Title  Print Name

Date  Time  Provider Signature/Title  Print Name

Copy:  Patient  □ Declined  □ Received