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*): _____	❑ **Neurologic Disease:** (*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

Operation	Month/Year	Reason for Surgery

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**)

BRISTOL STOOL CHART		
Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. **Entirely Liquid**

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)*

	Never	Less than once a month	Greater than once a month and less than once a week	Greater than once a week and less than daily	Daily or several times a day
Gas					
Liquid Stool					
Solid Stool					
Do you wear a pad?					
Does bowel leakage impact your quality of life?					

Difficult Evacuation: Difficulty emptying the bowels

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

	Never	Rarely	Sometimes	Usually	Always
Excessive Straining					
Incomplete rectal sensation					
Use of enema/laxatives					
Do you need to use a finger to help evacuate stool					
Abdominal discomfort /pain					

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

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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***)

	Yes	No	Sometimes	Sometimes, but it doesn't bother me	N/A
Are you sexually active?					
Do you have pain with sex?					
Do you have abnormal vaginal bleeding? (Bleeding between periods or after menopause)					
Do you feel a bulge or pressure in the vagina?					

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: _____

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

❑ I feel that my bladder never or rarely gets empty	❑ I have a weak stream all or most of the time
❑ I have to go back to the bathroom right after urinating	❑ I always have to strain to urinate
❑ I drip after I am finished urinating and walk away	❑ It takes a while to get started
❑ I've had a catheter before because I couldn't urinate	❑ My stream is stop and go
❑ 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 ❑ Staxyn

❑ 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)

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

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 _____ RELATIONSHIP TO PATIENT _____

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PROVIDER DOCUMENTATION

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