MEDICAL HISTORY QUESTIONNAIRE

Name_____ Date_____

Age_____ Birthdate/ ___/___/____ Race/Ethnicity_____

In order to help us provide you with the best medical care, please complete this form in as much detail as possible. Please bring the completed form with you at the time of your first visit. DO NOT MAIL IT.

Please write in your own words, the nature of your current gynecologic, colorectal or urologic medical problem.

Bladder Symptoms

Stress Incontinence Questions

Does coughing gently cause you to lose urine?
___ Often (3) ___ Sometimes (2) ___ Rarely (1) ___Never (0)

Does coughing hard cause you to loose urine?
___ Often (3) ___ Sometimes (2) ___ Rarely (1) ___Never (0)

Does sneezing cause you to lose urine?
___ Often (3) ___ Sometimes (2) ___ Rarely (1) ___Never (0)

Does lifting objects cause you to lose urine?
___ Often (3)___ Sometimes (2) ___ Rarely (1) ___Never (0)

Does bending over cause you to urine?
___ Often (3) ___ Sometimes (2) ___ Rarely (1) ___Never (0)

Does laughing cause you to lose urine?
___ Often (3) ___ Sometimes (2) ___ Rarely (1) ___Never (0)

Does walking briskly cause you to lose urine?
___ Often (3) ___ Sometimes (2) ___ Rarely (1) ___Never (0)

Does straining, if you are constipated, cause you to lose urine?
___ Often (3) ___ Sometimes (2) ___ Rarely (1) ___Never (0)

Does getting up from sitting to standing position cause you to lose urine?
___ Often(3) ___ Sometimes (2) ___ Rarely (1) ___Never (0)

If yes to any of the above questions, then for how long?
_____ Months Years

Urge Incontinence Questions

Some People receive very little warning and suddenly find that they are losing, or about to lose urine beyond their control. How often does this happen to you?
___ Often (3) ___ Sometimes (2) ___ Rarely (1) ___Never (0)

If yes, then how long?
____ (Months, Years)

If you can't find a toilet or find one that is occupied and you have an urge to urinate, how often do you end up losing urine and wetting yourself?
___ Often (3) ___ Sometimes (2) ___ Rarely (1) ___Never (0)

Do you lose urine when you suddenly have the feeling that your bladder is full?
___ Often (3) ___ Sometimes (2) ___ Rarely (1) ___Never (0)

Does washing your hands cause you to lose urine?
___ Often (3) ___ Sometimes (2) ___ Rarely (1) ___Never (0)

Does cold weather cause you to lose urine?
___ Often (3) ___ Sometimes (2) ___ Rarely (1) ___Never (0)

Does drinking cold beverages cause you to lose urine?
___ Often (3) ___ Sometimes (2) ___ Rarely (1) ___Never (0)

Do you use pads for urine leakage? Yes ___ No ____
If yes, what type of pad? _____

How often do you change your pad per day? _____

On average, how often do you urinate during the day?
____ times. And at Night? _____ times

Do you experience a burning sensation when you urinate? ____ Yes ____ No

Do you have blood in your urine? ____ Yes ____ No

Do you have more than 3 bladder infections per year?
___Yes ___ No

Do you have difficulty urinating or have a strain with urination? ___Yes ___No

Do you feel that your bladder does not empty completely?
___Yes ___ No

Do you have to push on a bulge in the vaginal area to empty your bladder? ____ Yes ____ No

Bela Vida Urogynecology

MEDICAL HISTORY QUESTIONNAIRE

VAGINAL PROLAPSE Symptoms

Do you experience pelvic pressure, heaviness or dullness? ___Yes ___No

Do you see or feel a bulge, or something falling out of the vaginal area? ___Yes ___ No

SEXUAL Symptoms

How long have you been with your current sexual partner?_____

Is your sex life satisfactory? ___ Yes ___ No

While answering the questions, consider your sexuality over the past six months.

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.
   ___ Always (4) ____ Usually (3) ____ Sometimes (2) ____ Seldom (1) ____Never (0)

2. Do you climax (have an orgasm) when having sexual intercourse with your partner?
   ___ Always (4) ____ Usually (3) ____ Sometimes (2) ____ Seldom (1) ____Never (0)

3. Do you feel sexually excited (turned on) when having sexual activity with your partner?
   ___ Always (4) ____ Usually (3) ____ Sometimes (2) ____ Seldom (1) ____Never (0)

4. How satisfied are you with the variety of sexual activities in your current sex life?
   ___ Always (4)____ Usually (3) ____ Sometimes (2) ____ Seldom (1) ____Never (0)

5. Do you feel pain during sexual intercourse?
   ___ Always (4) ____ Usually (3) ____ Sometimes (2) ____ Seldom (1) ____Never (0)

6. Are you incontinent of urine (leak urine) with sexual activity?
   ___ Always (4) ____ Usually (3) ____ Sometimes (2) ____ Seldom (1) ____Never (0)

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7. Does fear of incontinence (either stool or urine) restrict your sexual activity?
   ___ Always (4) ____ Usually (3) ____ Sometimes (2) ____ Seldom (1) ____Never (0)

8. Do you avoid sexual intercourse because of bulging in vagina (the bladder, rectum, or vagina falling out?
   ___ Always (4) ____ Usually (3) ____ Sometimes (2) ____ Seldom (1) ____Never (0)

9. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?
   ___ Always (4) ____ Usually (3) ____ Sometimes (2) ____ Seldom (1) ____Never (0)

10. Does your partner have a problem with erections that affects your sexual activity?
    ___ Always (4) ____ Usually (3) ____ Sometimes (2) ____ Seldom (1) ____Never (0)

11. Does your partner have a problem with premature ejaculation that affects your sexual activity?
    ___ Always (4) ____ Usually (3) ____ Sometimes (2) ____ Seldom (1) ____Never (0)

12. Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past 6 months?
    __Much less intense (0) __Less intense (1) ___ Same intensity (2) ___More intense (3) ___ Much more intense (4)

Do you have any questions about sex you would like to ask?
____ Yes___ No
Have you been a victim of domestic violence or sexual abuse?___Yes___No

BOWEL Symptoms

Do you have problems with:

Diarrea? ___ Yes___ No Constipation ___Yes ___ No

Fecal incontinence/leaking stool? ___ Yes ___ No

If yes, how long? _____

Do you leak solid stool? ___ Yes __No

Loose Stool? ___Yes/___ No Liquid Stool? ___Yes___No Gas?___Yes___ No

Do you leak stool with coughing, laughing, or physical activity? ___Yes ___No

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With urgency? ___Yes __No Anal/Rectal Bleeding? ___Yes __No

Change in bowel habits?___Yes ___ No

Anal pain or Hemorrhoids? ____ Yes___ No

Do you feel your bowels do not empty completely after a bowel movement? ___Yes___No

Do you have to push on the vagina or around the rectum to empty your bowels? ___ Yes___No

Frequency of bowel movements? _____day_____week

Have you had a colonscopy? ___Yes ___No

Date of last __/___/___ Results _____

Have you had prior surgery for prolapse or incontinence?

____ Yes ___No If yes, what surgeries? _____

GYNECOLOGIC/OBSTETICIAL HISTORY

Age when periods first started? _____

Date most recent menstrual period started ____/____/_____

Number of days from the start of one period to the start of the next period?_____

Are you periods regular? ____Yes___ No

How long do your periods last? _____

Do you have bleeding between periods? ____Yes ___No

Do you have bleeding during intercourse? ___Yes ___No

Do you have heavy menstrual periods?___Yes/ ___No

Do you have pain with periods?___Yes ____No

Birth Control Method?_____

Have you gone through menopause?_____Yes ___No. If yes, at what age? _____

Number of pregnancies? _____

Number of children born alive?_____

Number of miscarriages?_____

Number of abortions?_____

MEDICAL HISTORY QUESTIONNAIRE

Number of Ectopics (tubal)? _____

Type of deliveries (Number each type)

_____ Vaginal _____ Forceps

_____ C-Section/ Cesárea _____ Vacuum/ Succión

Weight of largest Vaginal delivery? _____ Pounds _____ Ounces

Tear into the rectum? ____ Yes ____ No

Are you taking estrogen replacement therapy?____ Yes ___No

If yes, which one? ____ Oral ____ Vaginal

Date of last Pap Smear? _____/_____/_____/ Normal ____Yes ____ No

Date of last Mammogram? _____/_____/_____ Normal ____ Yes____ No

Have you had any treatment to your cervix? ____ Yes ____ No

If yes, when? _____ Cautery_____ Cryosurgery_____ Other _____

Have you ever had a Sexually Transmitted Infection?

If yes, when? _____

_____ Herpes _____Trichomonas _____ Chlamydia

_____ HIV _____ Gonorrhea _____ Condyloma/Warts

_____ Pelvic Inflammatory Disease/PID

_____ Other

Have you had a Hysterectomy? ____ Yes_____ No

If yes, when and why? _____

_____ Abdominal _____ Vaginal _____ Laparoscopic

Have you had surgery to remove one or both ovaries?

____Yes ____ No

MEDICAL HISTORY QUESTIONNAIRE

PAST MEDICAL HISTORY:

(Check if your answer is yes)

- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Kidney Infection
- ☐ Diabetes
- ☐ Stroke
- ☐ Anxiety
- ☐ Depression
- ☐ Liver Disease
- ☐ Pneumonia
- ☐ Thyroid Disease
- ☐ Arthritis
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Cancer,Type _____
- ☐ Other_____

- ☐ Tuberculosis
- ☐ Serious Injuries or Accidents
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Reflux
- ☐ Any Implantable Devices
- ☐ Ulcer (Stomach, intestional)
- ☐ Antibiotics before procedures

SURGICAL HISTORY

(Check if your answer is yes and give the date of the surgery

Have you had any operations? ___ Yes ____ No

- ☐ Appendectomy – Date of Surgery _____
- ☐ Breast surgery (Biopsy, lumpectomy, mastectomy) – Date of Surgery_____
- ☐ Exploratory Laparotomy – Date of Surgery_____
- ☐ Bowel or Stomach Surgery – Date of Surgery_____
- ☐ Hip Surgery – Date of Surgery _____
- ☐ Spine Surgery – Date of Surgery _____
- ☐ Thyroid Surgery – Date of Surgery _____
- ☐ Gallbladder/Cholecystectomy – Date of Surgery _____
- ☐ Breast Plastic Surgery – Date of Surgery _____
- ☐ Diagnostic Laparoscopy – Date of Surgery_____
- ☐ Hernia Repair – Date of Surgery _____
- ☐ Knee Surgery – Date of Surgery _____
- ☐ Tonsillectomy – Date of Surgery _____
- ☐ Other _____ – Date of Surgery_____

Have you had any Blood Transfusions? _____Yes _____No

MEDICAL HISTORY QUESTIONNAIRE

FAMILY HISTORY

Has anyone in your family had any of these diseases? If so, please give a relationship

- ☐ High Blood Pressure _____
- ☐ Stroke _____
- ☐ Bleeding Problems _____
- ☐ Heart Disease_____
- ☐ Ovarian Cancer _____
- ☐ Diabetes_____
- ☐ Breast Cancer _____
- ☐ Colitis _____
- ☐ Colon/Rectal Cancer _____
- ☐ Other Cancer_____

List other Diseases _____

Father: _____Alive _____Deceased; if so, cause_____
Mother_____Alive_____Deceased if so, cause_____

SOCIAL HISTORY

Current marital status:

- ☐ Married ☐ Divorced/ ☐ Separated
- ☐ Single ☐ Widowed

Number of people living in your household? _____

Your Occupation? _____

HEALTH HABITS

Do you smoke? ____Yes____No
If yes, how many packs per day? _____
If no, did you smoke in the past?____Yes ____ No
If yes, how many packs per day?_____

Do you use alcohol?____Yes ____No
Do you use drugs? ____Yes ____No
Do you exercise regularly?____Yes ____No
If yes, what type of exercise do you do? _____

MEDICAL HISTORY QUESTIONNAIRE

Allergies

Do you have any allergies? ____Yes ____ No
If yes, please list: _____

MEDICATIONS

Please list all medicines which you are taking (including contraceptives, hormones, vitamins and over the counter medications) Use a separate sheet if necessary

Medication:_____ Dosage:_____

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

REVIEW OF SYMPTOMS

(Please check if any of the following symptoms apply)

Constitutional Symptoms

- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ Weight gain
- ☐ Other_____

Ear/Nose/Throat

- ☐ Ear pain
- ☐ Ringing in ears
- ☐ Decreased hearing
- ☐ Frequent bloody noses
- ☐ Sore Throat
- ☐ Other_____

MEDICAL HISTORY QUESTIONNAIRE

Eyes
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Eye pain
- ☐ Other/_____

Cardiovascular
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Passing out/loss of consciousness
- ☐ Swelling in legs
- ☐ Other_____

Respiratory
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Coughing up blood
- ☐ Wheezing/sibilancia
- ☐ Other/Otra_____

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Loss of appetite
- ☐ Abdominal Pain
- ☐ Black stool
- ☐ Indigestion/Heartburn
- ☐ Other_____

Genitourinary
- ☐ Vaginal Discharge
- ☐ Kidney Stones
- ☐ Other _____

Musculoskeletal
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Difficult Walking
- ☐ Other _____

Breast
- ☐ Breast Lumps
- ☐ Nipple Discharge
- ☐ Breast Pain
- ☐ Other _____

Neurologic
- ☐ Weakness
- ☐ Numbness/tingling
- ☐ Seizures
- ☐ Tremors
- ☐ Headaches
- ☐ Other _____

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Psychiatric Treatment
- ☐ Other_____

Endocrine
- ☐ Too cold
- ☐ Too hot
- ☐ Excessive thirst
- ☐ Fatigue
- ☐ Other_____

Hematologic
- ☐ Easy Bruising
- ☐ Bleeding
- ☐ Anemia/Low Blood Count/Anemia
- ☐ Swollen Glands
- ☐ Other_____

Allergic/Immunologic
- ☐ Hives
- ☐ Hay Fever
- ☐ Other _____

Skin/Piel
- ☐ Skin Rash
- ☐ Persistent itching
- ☐ Change in mole
- ☐ Other_____