



WOMEN'S PELVIC RESTORATIVE
CENTER

Ginger N. Cathey, MD
Urogynecology

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713-512-7823

Name: _____

Date of Appointment: _____

Date of Birth: _____

Date Completed: _____

Age: _____

Reason for visit: _____

Please provide name, address and **fax** or phone number for the following physicians or healthcare providers:

Who referred you to us? _____

Who is your primary care physician? _____

Who is your regular gynecologist? _____

Do you see any specialists?

Name, address, phone number

Gastroenterologist _____

Cardiologist _____

Urologist _____

Colorectal Surgeon _____

Other _____

History

URINARY INCONTINENCE

Yes **No**

Y N Do you have accidental loss of urine?

_____ How many months or years have you had leakage of urine?

Y N Do you wear pads to absorb lost urine?

_____ If yes, what size pad do you wear?

_____ How many pads do you wear in a day?

_____ How many trips to the bathroom do you make during the day from the time you wake up in the morning until the time you go to sleep at night?

Y N Does an uncomfortably strong need to pass urine wake you up?

_____ How many times are you awakened during the night after going to sleep by an urge to urinate?

Y N Does the sound, sight or feel of running water cause you to lose urine?

Y N Do you lose urine during the act of intercourse at penetration?

Y N Do you lose urine during orgasm?

Y N I lose urine during coughing, sneezing, running or heavy lifting

Y N I lose urine with changes in posture, standing or walking

Y N I lose urine continuously such that I am constantly wet

Y N Have you seen a physician for complaints of urine loss?

Y N Have you taken medicine to prevent urine loss?

If yes, name the medication _____

Y N Have you had surgery to prevent urine loss?

If yes, was it done through the vagina?

Was it done through the abdomen?

Y N Do you notice any dribbling or urine when you stand after passing your urine?

Y N Do you usually have difficulty starting your urine stream?

Y N Have you ever required catheterization for the inability to pass your urine?

Y N Do you always feel that your bladder is empty after passing urine?

Y N Have you seen any blood in your urine?

- Y N Do you have any burning with urination?
- Y N Have you had 3 or more urinary tract infections in the last year?

GENITOURINARY PROLAPSE

- Y N Do you have a bulge or mass in your vagina:
 _____ How many months or years have you had this bulge or mass?
- Y N Have you seen a doctor for this bulge or mass in your vagina?
- Y N Have you worn a pessary for this problem?
 _____ If yes, how many months or years have you worn this pessary?
- Y N Have you had surgery in the past for a bulge or mass in the vagina?

FECAL INCONTINENCE

- Y N Do you have accidental loss of solid stool?
- Y N Do you have accidental loss of liquid stool?
- Y N Do you have accidental loss of gas?
 ___yr___mo How long have you had accidental loss of stool or gas?
- Y N Have you seen a doctor for this problem?
- Y N Did the problem with accidental loss of stool begin after childbirth?
- Y N Do you wear protective pads for this problem?
 _____ If yes, what size pad do you wear?
 _____ How many pads do you wear each day?
- Y N Are you able to sense the need to have a bowel movement?
- Y N Are you able to tell the difference between solid stool/liquid stool/gas?
- Y N Do you have a frequent desire to have a bowel movement?
- Y N Have you had surgery for this problem?
- Y N Has there been a change in your bowel habits recently?
- Y N Have you noticed any bright red bleeding with your bowel movements?

Y N Have you noticed black or "tarry" stools?

Y N Are your bowel movements painful?

CONSTIPATION

Y N Do you have constipation?

Y N Do you excessively strain to pass stool more than 25% of the time?

Y N Do you have at least three bowel movements each week?

_____ How many bowel movements do you have each week?

Y N Do you pass hard, small stool?

__yr__mo How many months or years have you had constipation?

Y N Have you seen a doctor for this problem?

Y N Do you use any medication or over the counter products for this?
If yes, what have you used? _____

Y N Have you had surgery for this problem?

Y N Have you ever placed your hand or fingers in your vagina or between
your vagina and rectum to help bring about a bowel movement?

Y N Do you have a feeling of incomplete emptying after bowel movements?

Y N Have you had a colonoscopy? Date: _____ Results: _____

PAST GYN HISTORY

Last pap test (month & year): _____

Have you ever had an abnormal pap smear? Yes No If yes, what year _____

Last mammogram (month & year): _____

Have you ever had an abnormal mammogram? Yes No If yes, what year _____

Y N Have you gone through menopause?
If yes, at what age did you go through menopause? _____

Y N Are your periods regular? How many days do you bleed? _____

Y N Have you had any vaginal bleeding or spotting since menopause?

Y N Have you had a hysterectomy?

If yes, was it done through the vagina or abdomen or laparoscopically ? (Please circle)

Y N Do you have your ovaries?
If yes, both or only one (Please circle)

Y N Have you had surgery for leakage of urine?

Y N Have you had surgery for prolapse, "bulges" or "fallen pelvic organs"?

PAST OBSTETRICAL HISTORY

Number of Pregnancies _____
Number of Vaginal Births _____ Number of C-Sections _____
Elective terminations _____ Miscarriages _____ Ectopics _____
Weight of Largest Baby _____

SEXUAL HISTORY

Y N Sexually Active? If no, why? Please circle
1. No partner 4. Painful intercourse
2. Partner factor 5. Because of bulge or leak symptoms
3. Loss of sex drive 6. Other

Partner: Male Female Both (Please circle)

Y N Contraception? If yes, please circle
1. Tubal ligation 5. Depo-provera
2. Birth control pills 6. Barrier/ Condemns
3. Intrauterine device IUD 7. Postmenopausal
4. Partner vasectomy 8. Other _____

Y N Pain with intercourse: If yes, please circle one or both
1. Near vaginal opening
2. Inside abdomen/pelvic area

SURGERIES / HOSPITALIZATIONS

Date(s) and reason(s) for surgery/hospitalization:

INJURIES/ILLNESSES

Date(s) and description(s) of injuries and/or illnesses:

PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the following?

Y	N	Anemia	Y	N	Heart Murmur
Y	N	Anesthesia Problems	Y	N	Hepatic / Liver Disease
Y	N	Anxiety Disorder	Y	N	High Cholesterol
Y	N	Arrhythmia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	IBS
Y	N	Asthma	Y	N	Immunologic Disorder
Y	N	Bleeding Disorder	Y	N	Kidney Stones
Y	N	Blood Clots/ DVT/ PE	Y	N	MI (Heart Attack)
Y	N	Breast Cancer	Y	N	Migraine Headaches
Y	N	Cancer _____	Y	N	Neurological Disorder__
Y	N	CVA/ Stroke	Y	N	Osteoporosis
Y	N	Chronic Lung Disease	Y	N	Psychiatric Illness _____
Y	N	Chronic Pain _____	Y	N	Seizures/ Epilepsy
Y	N	Congestive Heart Failure	Y	N	Sleep Apnea
Y	N	Coronary Artery Disease	Y	N	Skin Disorder
Y	N	Depression	Y	N	Substance Abuse
Y	N	Diabetes Mellitus	Y	N	STD _____
Y	N	Diverticulitis	Y	N	Renal / Kidney Disease
Y	N	Fibromyalgia	Y	N	Thyroid Disease
Y	N	Gastric Reflux/ Ulcers	Other		
Y	N	Gastrointestinal Disease	_____		
Y	N	Glaucoma	_____		
Y	N	HIV/ AIDS	_____		
Y	N	Hepatitis	_____		

FAMILY HISTORY

Has a **blood-related** family member had any of these illnesses:

Yes	No	Don't Know		Relationship
Y	N	?	Diabetes	_____
Y	N	?	Stroke	_____
Y	N	?	Heart disease	_____
Y	N	?	High blood pressure	_____
Y	N	?	Breast cancer	_____
Y	N	?	Colon cancer	_____
Y	N	?	Ovarian cancer	_____
Y	N	?	Prolapse	_____
Y	N	?	Urinary incontinence	_____
Y	N	?	Fecal incontinence	_____

PERSONAL AND SOCIAL HISTORY

Who lives in your home with you? _____

Current marital status: Married _____ Divorced _____ Single _____ Widowed _____

Ethnic Background: Caucasian _____ African-American _____
Hispanic _____ Asian _____ Other _____

Y N Are you employed? If so, occupation: _____

Y N Does your job or a hobby require heavy physical work?

Education

Level of Education: ___ Up to 12th Grade ___ Beyond 12th Grade Degree: _____

Personal Habits

Y N Smoking Packs per day: _____ Years of use: _____

Y N Alcohol Drinks per day: _____ Drinks per week: _____

Y N Recreational Drug Use What type? _____ How often? _____

MEDICATIONS / PRODUCTS / HERBALS

(Please bring medications in the original bottles for us to review if not recorded)

Name	Dosage	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

_____	Symptoms: _____
_____	Symptoms: _____
_____	Symptoms: _____
_____	Symptoms: _____
_____	Symptoms: _____
_____	Symptoms: _____

REVIEW OF SYSTEMS

Please check appropriate box if any of the following apply to you and these are problems that have not been evaluated prior. If checked, please explain.

Notes

- 1. Constitutional**
 - Weight loss _____
 - Weight gain _____
 - Fever/ Chills _____
 - Fatigue _____

- 2. Eyes**
 - Double vision _____
 - Spots before eyes _____
 - Vision changes _____

- 3. ENT/Mouth**
 - Ear aches _____
 - Sinus problems _____
 - Sore throat _____
 - Mouth sores _____
 - Dental problems _____

- 4. Cardiovascular**
 - Chest pain _____
 - Difficult breathing on exertion _____
 - Swelling of legs _____
 - Palpitations of heart _____

- 5. Respiratory**
 - Wheezing _____
 - Spitting up blood _____
 - Shortness of breath _____
 - Chronic cough _____

- 6. Gastrointestinal**
 - Abdominal Pain _____
 - Blood in stool _____
 - Nausea/vomiting _____

- 7. Musculoskeletal**
 - Muscle weakness _____
 - Joint pain _____
 - Back pain _____

REVIEW OF SYSTEMS - Continued

Notes

- | | | |
|----------------------------------|--------------------------|-------|
| 8. Skin/Breast | | |
| Pain in breast | <input type="checkbox"/> | _____ |
| Discharge | <input type="checkbox"/> | _____ |
| Masses | <input type="checkbox"/> | _____ |
| Rash | <input type="checkbox"/> | _____ |
| Ulcers | <input type="checkbox"/> | _____ |
| 9. Neurological | | |
| Dizzy spells | <input type="checkbox"/> | _____ |
| Seizures | <input type="checkbox"/> | _____ |
| Numbness/ tingling | <input type="checkbox"/> | _____ |
| Trouble walking | <input type="checkbox"/> | _____ |
| 10. Psychiatric | | |
| Depression | <input type="checkbox"/> | _____ |
| Frequent Crying | <input type="checkbox"/> | _____ |
| Thoughts of Suicide | <input type="checkbox"/> | _____ |
| 11. Endocrine | | |
| Dry skin | <input type="checkbox"/> | _____ |
| Abnormal thirst | <input type="checkbox"/> | _____ |
| Hot flashes | <input type="checkbox"/> | _____ |
| 12. Hematologic/lymphatic | | |
| Frequent bruises | <input type="checkbox"/> | _____ |
| Cuts that don't stop bleeding | <input type="checkbox"/> | _____ |
| Enlarged lymph nodes | <input type="checkbox"/> | _____ |
| 13. Allergic/immunologic | | |
| Allergies | <input type="checkbox"/> | _____ |
| Drug/ Latex allergies | <input type="checkbox"/> | _____ |

Please list any other concerns you may have regarding your medical history and care.

Completed by: Patient Family Member Office Nurse Physician

Signature of patient: _____

Date reviewed by physician with patient: _____

Physician signature: _____

Revised: 07/31/23 GNC