Northwest Gynecology Center

Patient Intake Form

We take your health seriously and will be using the information you provide here to help us understand your problems and take better care of you.

About You

Appointment Date: _____

Your Name:_____ Date of Birth (mm/dd/yyyy): _____

Street Address: _____ Age: _____

City: _____ Home Phone: _____

State:_____ Work Phone: _____

Zip: _____ Cell Phone:_____

1. What is your marital status? *(Check one)*
   - ❑ Married
   - ❑ Divorced
   - ❑ Widowed
   - ❑ Separated
   - ❑ Never married
   - ❑ Long-term partner
2. What is your occupation? If you are retired, what activities occupy most of your time? _____
   _____
3. Do your free time activities or your occupation require: *(Check all that apply)*
   - ❑ Sitting
   - ❑ Lifting
   - ❑ Standing
   - ❑ Pushing/pulling
4. How did you hear about us/who referred you to us?
   - ❑ TV
   - ❑ Friend
   - ❑ Medical provider, (name): _____
   - ❑ Web site
   - ❑ Brochure
   - ❑ Other: _____
5. Who is your primary care provider?_____

Why are you here today?

6. For what condition(s) are you seeking treatment? *(Check all that apply)*

No	Yes	Symptom	If **yes**, how long have you had this symptom? Less than a year	1-2 years	3-5 years	More than 5 years
❑	❑	Urinary incontinence (problem with bladder control)	❑	❑	❑	❑
❑	❑	Anal incontinence (problem with bowel control)	❑	❑	❑	❑
❑	❑	Pelvic prolapse (bulge or protrusion in the vagina)	❑	❑	❑	❑
❑	❑	Urgency	❑	❑	❑	❑
❑	❑	Too frequent voiding/urinating	❑	❑	❑	❑
❑	❑	Pelvic pain	❑	❑	❑	❑
❑	❑	Other (specify): _____	❑	❑	❑	❑

If you need more space to describe your reasons for seeking treatment, please use the back of this page.

7. What would you be willing to do to improve your condition? *(Check all that apply)*
   - ❑ Lose weight
   - ❑ Stop smoking
   - ❑ Physical therapy/exercise for the pelvic floor muscles
   - ❑ Diet/lifestyle modification
   - ❑ Take medication
   - ❑ Have surgery
   - ❑ Conservative management (combination of treatments to specifically avoid surgery)

8. What have you done *in the past* to improve your symptoms?_____
   _____
   _____
   _____

9. What are your goals for treatment? *(Check all that apply)*
   - ❑ To not leak urine
   - ❑ To improve bladder or bowel function
   - ❑ To be normally active
   - ❑ Other (specify):_____

10. How *motivated* are you to take part in treatment or therapy?
    ❑ Not at all ❑ Somewhat ❑ Very ❑ Extremely

11. In general, would you say that your health is:
    ❑ Poor ❑ Fair ❑ Good ❑ Very Good ❑ Excellent

12. What is your current activity level?
    ❑ Sedentary ❑ Light ❑ Moderate ❑ Heavy

Menstruation

Answer questions 13-15 ONLY IF you are STILL menstruating.

13. When was your last menstrual period?_____
14. Is there any possibility you could be pregnant? ❑ No ❑ Yes
15. What type of birth control do you and your partner use?_____

Answer questions 16 & 17 ONLY IF you are NO LONGER menstruating.

16. Are you going through or have you gone through menopause? ❑ No ❑ Yes
17. Are you currently using hormones? ❑ No ❑ Yes

Birth

Answer questions 18-21 ONLY IF you HAVE given birth.

18. How many children have you given birth to? Vaginal:_____ Cesarean Section:_____
19. Did any of your children weigh 8 pounds or more? ❑ No ❑ Yes
20. Did you have any of the following? *(Check all that apply)*
    ❑ Severe tearing/cutting or episiotomy ❑ Forceps delivery ❑ Vacuum delivery
21. Did you have problems with incontinence within the first few weeks after delivery?
    Urinary Incontinence ❑ No ❑ Yes ❑ Don't know/remember
    Stool Incontinence ❑ No ❑ Yes ❑ Don't know/remember

Medical History

22. Have you had any of the following?
    ❑ Heart surgery ❑ Colon surgery ❑ Ovaries removed
    ❑ Kidney surgery ❑ Vascular surgery ❑ Pelvic physical therapy
    ❑ Radiation therapy to abdomen/pelvis for treatment of cancer
    Please list all other surgeries: _____
23. Have you had a hysterectomy? ❑ No ❑ Yes
    If yes, was the incision ❑ Abdominal ❑ Vaginal ❑ Laparoscopic/robotic ❑ Don't know
24. Have you had bladder surgery? ❑ No ❑ Yes
    If yes, was the incision ❑ Abdominal ❑ Vaginal ❑ Laparoscopic/robotic ❑ Don't know
    If yes, was mesh used? ❑ No ❑ Yes ❑ Don't know
25. Have you had prolapse surgery? ❑ No ❑ Yes
    If yes, was the incision ❑ Abdominal ❑ Vaginal ❑ Laparoscopic/robotic ❑ Don't know
    If yes, was mesh used? ❑ No ❑ Yes ❑ Don't know
26. Have you had rectal surgery? ❑ No ❑ Yes
    If yes, was the incision ❑ Abdominal ❑ Vaginal ❑ Laparoscopic/robotic ❑ Anal ❑ Don't know
    If yes, was mesh used? ❑ No ❑ Yes ❑ Don't know

27. Check any of the following medical conditions that you currently have or have had in the past:

❑ Asthma	❑ Heart Attack	❑ Stroke	❑ Arthritis
❑ Emphysema/COPD	❑ Irregular Heart Beat	❑ Seizures	❑ Back Injury
❑ Tuberculosis	❑ Hemiplegia	❑ Abnormal Pap Smear	❑ Fibromyalgia
❑ Pneumonia	❑ Leukemia	❑ Pelvic Infection	❑ Depression/Anxiety
❑ Thyroid Disease	❑ Lymphoma	❑ HIV/AIDS	❑ Dementia
❑ Diabetes	❑ Cancer	❑ Blood Clots (not menstrual)	❑ Glaucoma
❑ Diabetes With End Organ Failure	Cancer Type/Location: _____	❑ Bleeding/Bleeding Problems	Type of Glaucoma: _____
❑ Congestive Heart Failure	❑ Kidney Disease (moderate to severe)	❑ Peripheral Vascular Disease	❑ Connective Tissue Disease
❑ Hypertension (High Blood Pressure)	❑ Kidney Stones	❑ Kidney Infection	❑ Intestinal Problems
❑ Heart Disease	❑ Liver Disease	❑ Ulcers	

Is there is anything you would like us to know about one of these conditions? Do you have, or have you had, a condition not listed above? Please tell us about it on the back of this page.

Medications

28. Do you take any of the following medications?

	No	Yes	Dose	Frequency
Amitriptyline	❑	❑		
Detrol	❑	❑		
Ditropan	❑	❑		
Oxytrol/ Gelnique	❑	❑		
Sanctura	❑	❑		
Vesicare	❑	❑		
Enabelex	❑	❑		
Cymbalta	❑	❑		
Fiber, (Metamucil , Citrucel, FiberCon, Psyllium, Fiberall, Hydrocil, Konsil, Benefiber, Other)	❑	❑		
Colace	❑	❑		
Laxatives, (Senokot, Ex-Lax, Correctal, MiraLax, Other)	❑	❑		

List all of your other medications. If you run out of room, please continue on the back or attach page.

Medication	Dose	Frequency	**Medication**	Dose	Frequency

29. Do you have any allergies to medications? ❑ No ❑ Yes
If yes, what are they?_____

30. Do you have any **allergies** to the following? *(Check all that apply)*
❑ Latex ❑ Tape ❑ Iodine/contrast

31. Do you have a **family history** of any of the following diseases? *(Check all that apply)*

❑ High blood pressure ❑ Heart disease ❑ Diabetes

❑ Problems similar to what you are being seen for at this visit

❑ Cancer (indicate type): ❑ Breast ❑ Colon ❑ Ovarian ❑ Bladder/Kidney ❑ Other cancer

❑ Other disease:_____

32. Do you smoke cigarettes? ❑ No ❑ Yes

If **YES**, how many packs a day do you smoke? ❑ Less than 1 ❑ 1-2 packs ❑ Greater than 2

If **NO**, did you used to smoke? ❑ No ❑ Yes

If **YES**, how long ago did you used to smoke? _____

33. Do you currently drink caffeinated beverages? ❑ No ❑ Yes
(coffee, tea, soda, energy drinks, etc.)

If **YES**, how many cups per day?_____

34. During the last 30 days, have you had at least one drink of ANY kind of alcoholic beverages (including beer, wine or mixed drinks)? ❑ No ❑ Yes

If **YES**, which statement comes closest to describing how often you drank any alcoholic beverage in the last 30 days?

❑ Every day ❑ 1-2 days per week

❑ 5-6 days per week ❑ 2-3 times in the last 30 days

❑ 3-4 days per week ❑ Once in the last 30 days

35. Recently (in the past few weeks) have you been bothered by: *(Circle all that apply)*

General: Excessive weight gain / Weight loss / Fever / Chills

Endocrine: Cold intolerance / Excessive thirst

Eyes, Ears, Nose & Throat: Visual changes / Hearing loss / Headaches

Respiratory: Coughing / Wheezing / Shortness of breath

Cardiovascular: Chest Pain / Irregular heart rate / Swelling in legs

Breast: Breast pain / Lumps / Nipple discharge

Skin: Skin changes or rashes

Gastrointestinal: Nausea / Vomiting / Difficulty swallowing / Diarrhea

Musculoskeletal: Joint pain / Joint swelling / Muscle cramps

Psychological: Depression / Anxiety / Mood changes

Hematology: Easy bruising / Excessive bleeding / Night sweats

Neurological: Dizziness / Weakness / Tingling sensations / Slurred speech

36. Now thinking about your mental health, which includes stress, depression and problems with emotions, how many **DAYS** during the past 30 DAYS (the last month) was your mental health **NOT** good? (Your answer should be between 0-30 days.) **___ Days**

Your Symptoms

37. How many times per day do you urinate? _____

38. How many times do you wake up at night to urinate? _____

39. Do you ever wake up with urine on clothes/bed?

40. Do you have difficulty starting urination? ❑ No ❑ Yes

41. Do you have to strain to urinate? ❑ No ❑ Yes

42. Is your urine flow weak? ❑ No ❑ Yes

43. Do you leak *immediately* after emptying your bladder (when you walk away from the toilet)? ❑ No ❑ Yes

44. Do you ever see blood in your urine? ❑ No ❑ Yes

45. Do you get frequent bladder infections? ❑ No ❑ Yes

46. How often do you experience urinary leakage?
    - ❑ Less than once a month
    - ❑ A few times a month
    - ❑ A few times a week
    - ❑ Every day and/or night

47. How much urine do you lose each time?
    - ❑ Drops
    - ❑ Small splashes
    - ❑ More

48. How many pads per day do you use for leakage protection? _____ pads/day

49. How many bowel movements do you have? _____ per day _____ per week

50. Have you ever seen blood in your stool? ❑ No ❑ Yes

Tools

The next pages contain special sets of questions that can help us to better understand your condition. Each set of questions has been scientifically tested and accurately measures a specific medical condition that we frequently see. Not all of the questions will apply to you. These sets of questions must be asked the same way each time to be valid. Some of the tools overlap slightly, so the questions may seem repetitive. They will help us provide you with the best quality of care and will help us measure your treatment outcomes. They will also help us improve the quality of care we provide.

We would like to know if you have certain bowel, bladder or pelvic symptoms. If you do, we'd also like to know how much they bother you.

- Please answer **all** of the questions in the following survey.
- Answer by filling the appropriate circle or circles.
- When answering, please consider your symptoms **over the last 3 months**.

Do you…		No	Yes	**If yes, how much does this bother you?** Not at all	Some-what	Moder-ately	Quite A bit
1.	Usually experience *pressure* in the lower abdomen?	❍	❍	❑	❑	❑	❑
2.	Usually experience *heaviness* or *dullness* in the pelvic area?	❍	❍	❑	❑	❑	❑
3.	Usually have a bulge or something falling out that you can see or feel in the vaginal area?	❍	❍	❑	❑	❑	❑
4.	Usually have to push on the vagina or around the rectum to have or complete a bowel movement?	❍	❍	❑	❑	❑	❑
5.	Usually experience a feeling of incomplete bladder emptying?	❍	❍	❑	❑	❑	❑
6.	Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	❍	❍	❑	❑	❑	❑
7.	Feel you need to strain too hard to have a bowel movement?	❍	❍	❑	❑	❑	❑
8.	Feel you have not completely emptied your bowels at the end of a bowel movement?	❍	❍	❑	❑	❑	❑
9.	Usually lose stool beyond your control if your stool is well formed?	❍	❍	❑	❑	❑	❑
10.	Usually lose stool beyond your control if your stool is loose?	❍	❍	❑	❑	❑	❑
11.	Usually lose gas from the rectum beyond your control?	❍	❍	❑	❑	❑	❑
12.	Usually have pain when you pass your stool?	❍	❍	❑	❑	❑	❑
13.	Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	❍	❍	❑	❑	❑	❑
14.	Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	❍	❍	❑	❑	❑	❑
15.	Usually experience frequent urination?	❍	❍	❑	❑	❑	❑
16.	Usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?	❍	❍	❑	❑	❑	❑

Continued on next page

				If yes, how much does this bother you?			
Do you…		No	Yes	Not at all	Some-what	Moder-ately	Quite A bit
17.	Usually experience urine leakage related to coughing, sneezing or laughing?	❍	❍	❑	❑	❑	❑
18.	Usually experience small amounts of urine leakage (that is, drops)?	❍	❍	❑	❑	❑	❑
19.	Usually experience difficulty emptying your bladder?	❍	❍	❑	❑	❑	❑
20.	Usually experience *pain* or *discomfort* in the lower abdomen or genital region?	❍	❍	❑	❑	❑	❑
21.	If you answered **YES** to question 20, then is your pain relieved after emptying your bladder?			❑ No		❑ Yes	

Your Activities

Some women find that bladder, bowel or vaginal symptoms affect their activities, relationships and feelings. For each question, mark the box that best describes how much your activities, relationships or feelings have been affected by your bladder, bowel or vaginal symptoms **over the last 3 months**.

Please make sure to answer all 3 columns for each question.

	How do symptoms or conditions related to the following → usually affect your:	**Bladder or Urine**	**Bowel or Rectum**	**Vagina or Pelvis**
1.	Ability to do household chores (cooking, housecleaning, laundry)?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
2.	Ability to do physical activities such as walking, swimming or other exercise?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
3.	Entertainment activities such as going to a movie or concert?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
4.	Ability to travel by car or bus for a distance greater than 30 minutes away from home?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit

	How do symptoms or conditions related to the following → usually affect your:	Bladder or Urine	Bowel or Rectum	Vagina or Pelvis
5.	Participating in social activities outside your home?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
6.	Emotional health (nervousness, depression, etc.)?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit
7.	Feeling frustrated?	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit	❑ Not at all ❑ Somewhat ❑ Moderately ❑ Quite a bit

Your Sexuality

Following is a list of questions about you and your partner's sex life. All information is strictly confidential. Your confidential answers will be used only to help your doctor understand what is important to patients about their sex lives. Please check the box that best answers the question for you. When answering the following questions, please consider your sexuality **over the past 6 months**.

1. If you are <u>not</u> sexually active, please mark the reason that best explains why:
   - ❑ No interest
   - ❑ No partner
   - ❑ Partner is not able
   - ❑ Other

   If you **ARE NOT** sexually active, **skip** to question 14 on page 10.

   If you **ARE** sexually active, **complete** all that apply**.**

		Never	Seldom	Some-times	Usually	Always
2.	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.	❑	❑	❑	❑	❑
3.	Do you climax (have an orgasm) when having <u>sexual intercourse</u> with your partner?	❑	❑	❑	❑	❑
4.	Do you feel sexually excited (turned on) when engaging in sexual activity with your partner?	❑	❑	❑	❑	❑
5.	How satisfied are you with the variety of sexual activities in your current sex life?	❑	❑	❑	❑	❑

		Never	Seldom	Some-times	Usually	Always
6.	Do you feel pain during sexual intercourse?	❑	❑	❑	❑	❑
7.	Are you incontinent of urine (leak urine) with sexual activity?	❑	❑	❑	❑	❑
8.	Does fear of incontinence (either stool or urine) restrict your sexual activity?	❑	❑	❑	❑	❑
9.	Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum or vagina falling out)?	❑	❑	❑	❑	❑
10.	When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?	❑	❑	❑	❑	❑
11.	Does your partner have a problem with erections that affects your sexual activity?	❑	❑	❑	❑	❑
12.	Does your partner have a problem with premature ejaculation that affects your sexual activity?	❑	❑	❑	❑	❑
		Much less intense	**Less intense**	**Same intensity**	**More intense**	**Much more intense**
13.	Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?	❑	❑	❑	❑	❑

14.	Have you ever been raped or forced to engage in sexual activity against your will?	❑ No	❑ Yes
15.	Have you been hit, punched or otherwise hurt by someone within the past year?	❑ No	❑ Yes
16.	Do you feel unsafe in your current relationship?	❑ No	❑ Yes
17.	Is there a partner from a previous relationship who is making you feel unsafe now?	❑ No	❑ Yes

18. Is there anything you would like to add? (If you run out of room, please continue on the back.) _____

_____

_____

_____

_____

Bowel Symptoms

Please complete this questionnaire if you have any trouble controlling gas or bowel movements. If you **DO NOT**, then you are finished completing this questionnaire. Thank you for taking the time to do so. We greatly appreciate your efforts.

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 one box per row)*

		2 or More Times a Day	Once a Day	2 or More Times a Week	Once a week	1 to 3 Times a Month	Never
1.	Gas						
2.	Mucus						
3.	Liquid Stool						
4.	Solid Stool						

For each of the following items, please indicate how much of the time the issue is a concern for you due to accidental bowel leakage. (If it is a concern for you for reasons other than accidental bowel leakage then check the box under Not Apply, (N/A).)

5. In general, would you say that your health is:
   ❑ Poor ❑ Fair ❑ Good ❑ Very Good ❑ Excellent

	Due to accidental bowel leakage:	**Most of the time**	**Some of the time**	**A Little of the Time**	**None of the time**	**N / A**
6.	I am afraid to go out					
7.	I avoid visiting friends					
8.	I avoid staying overnight away from home					
9.	It is difficult for me to get out and do things like going to a movie or to church					
10.	I cut down on how much I eat before I go out					
11.	Whenever I am away from home, I try to stay near a restroom as much as possible					
12.	It is important to plan my schedule (daily activities) around my bowel pattern					
13.	I avoid traveling					
14.	I worry about not being able to get to the toilet in time					
15.	I feel I have no control over my bowels					
16.	I can't hold my bowel movement long enough to get to the bathroom					
17.	I leak stool without even knowing it					
18.	I try to prevent bowel accidents by staying very near a bathroom					

Due to accidental bowel leakage, indicate the extent to which you **AGREE** or **DISAGREE** with each of the following items. (If it is a concern for you for reasons other than accidental bowel leakage, check the box under Not Apply, (N/A).)

	Due to accidental bowel leakage:	**Strongly Agree**	**Somewhat Agree**	**Somewhat Disagree**	**Strongly Disagree**	**N/A**
19.	I feel ashamed	❑	❑	❑	❑	❑
20.	I cannot do many of the things I want to do	❑	❑	❑	❑	❑
21.	I worry about bowel accidents	❑	❑	❑	❑	❑
22.	I feel depressed	❑	❑	❑	❑	❑
23.	I worry about others smelling stool on me	❑	❑	❑	❑	❑
24.	I feel like I am not a healthy person	❑	❑	❑	❑	❑
25.	I enjoy life less	❑	❑	❑	❑	❑
26.	I have sex less often than I would like to	❑	❑	❑	❑	❑
27.	I feel different from other people	❑	❑	❑	❑	❑
28.	The possibility of bowel accidents is always on my mind	❑	❑	❑	❑	❑
29.	I am afraid to have sex	❑	❑	❑	❑	❑
30.	I avoid traveling by plane or train	❑	❑	❑	❑	❑
31.	I avoid going out to eat	❑	❑	❑	❑	❑
32.	Whenever I go someplace new, I specifically locate where the bathrooms are	❑	❑	❑	❑	❑

33. During the past month, have you felt so sad, discouraged, hopeless or had so many problems that you wondered if anything was worthwhile?

- ❑ Extremely so, to the point that I have just about given up
- ❑ Very much so
- ❑ Quite a bit
- ❑ Some, enough to bother me
- ❑ A little bit
- ❑ Not at all

Thank you very much for completing this questionnaire. It will help us take better care of you.