Weill Cornell Medicine
Obstetrics & Gynecology

New Urogynecology Patient Intake Form

Please complete this brief history to assist me in providing you with the best care possible.
This form will be added to your medical record.

Name: _____ Preferred Name _____ Preferred Pronoun(i.e. she/he; her/him) _____
Date of Birth: 0 _____ Who referred you? _____
Reason for visit: _____

Sexuality/Gender Identity

What is your sexual orientation?
☐Straight/Heterosexual
☐Lesbian/Gay
☐Bisexual
☐Other _____
☐Decline to state

What sex were you assigned at birth?
☐Female
☐Male
☐Decline to state

What is your gender identity?
☐Female
☐Transgender woman/Transwoman
☐Male
☐Transgender man/Transman
☐Gender queer/Gender non -conforming
☐Decline to state

Gynecologic History

Date of last menstrual period: _____

Age (years) at 1st period _____; My period usually occurs every_____ days and lasts for _____days; Age at Menopause_____

Do you have a history of (If yes please provide date and describe):

☐ Ovarian cysts _____
☐ Fibroids _____
☐ Abnormal Pap test _____
☐ Sexually Transmitted Infection _____

Have you ever used oral contraceptives (if so for how many years)? _____

Have you ever used hormone replacement therapy (if so for how many years)? _____

Are you sexually active? ☐ No ☐ Yes Any problems? _____

Total number of pregnancies _____

# of Vaginal deliveries ___; Cesarean sections ___; Miscarriages ___; Abortions ___; Ectopic pregnancies ___;

Pregnancy Complications_____

Obstetrics History

Deliveries: Vaginal delivery dates: _____ ; Cesarean section delivery dates: _____ ;

Infant birth weights: _____ ; Foreceps/Vacuum ☐ No ☐Yes; Episiotomy/Laceration ☐ No ☐Yes

Current Medications (include vitamins, herbs and other supplements)

Please review your attached medication list. Please add/remove medications based on what you currently take.

Name of Medication	Dosage	How Often

Allergies

Are you allergic to any medications? ☐ No ☐ Yes (Please specify the medication and reaction):

Medical History (either now or in the past/detail below with year of diagnosis and treatment given)

☐ Asthma
☐ Cancer
☐ Cardiac disease
☐ Diabetes
☐ Hypertension / high blood pressure
☐ Hyperlipidemia / cholesterol
☐ Irritable bowel syndrome
☐ Inflammatory bowel disease
☐ Lupus
☐ Osteoporosis / osteopenia
☐ Stroke
☐ Thrombotic disorder (blood clots)
☐ Thyroid disease (low / high)
☐ Reflux (GERD)

Psychiatric diagnosis
☐ Anxiety
☐ Depression
☐ Bipolar disorder
☐ Other: _____
_____
_____

Name: _____ Date of visit: _____

Surgical History

Name of Procedure	Date of Procedure	Reason for Procedure

Family History

Do you have a family member with any of the following cancers (if yes please list which family member and age of diagnosis)

- ☐ Breast cancer _____
- ☐ Ovarian cancer _____
- ☐ Uterine/endometrial cancer _____
- ☐ Prostate cancer _____
- ☐ Pancreatic cancer _____
- ☐ Colon cancer _____
- ☐ Melanoma _____
- ☐ Other cancer (specify) _____

Mother: ☐ Living ☐ Deceased (cause) _____

Father: ☐ Living ☐ Deceased (cause) _____

Siblings: Number living: _____ Number deceased: _____ Cause: _____

Social History

Do you exercise? If so what do you do _____

Occupation_____ Marital Status_____

Do you smoke? _____ How many packs a day? _____ If you quit, when was this? _____

Do you drink alcohol? _____ How many drinks per week? _____ Any other drugs? _____ Which other drugs?_ _____

Review of Systems: Are you experiencing any of the following symptoms?					
Constitutional	☐ No	☐ Weight loss	☐ Weight gain	☐ Fever	☐ Fatigue
Eye Problems	☐ No	☐ Vision Changes	☐ Glasses	☐ Contacts	☐ Other
Ear, Nose, Throat	☐ No	☐ Ulcers	☐ Sinusitis	☐ Headache	☐ Hearing Problems
Cardiovascular	☐ No	☐ Chest pain	☐ Leg Swelling	☐ Palpitations	☐ Other
Respiratory	☐ No	☐ Wheezing	☐ Cough	☐ Shortness of Breath	☐ Other
Gastrointestinal	☐ No	☐ Diarrhea	☐ Constipation	☐ Nausea	☐ Vomiting
Urinary	☐ No	☐ Painful Urination	☐ Urgency	☐ Frequency	☐ Bloody Urine
Skin/Breast	☐ No	☐ Breast Pain	☐ Nipple discharge	☐ Breast Mass	☐ Skin Rash
Neurological	☐ No	☐ Fainting	☐ Seizures	☐ Numbness	☐ Trouble Walking
Psychiatric	☐ No	☐ Depression	☐ Anxiety	☐ Other	
Blood/Lymph	☐ No	☐ Easy Bruising	☐ Abnormal Bleeding	☐ Swollen Glands	☐ Other
Musculoskeletal	☐ No	☐ Weakness	☐ Pain	☐ Other	

Physicians

Medical / primary care physician: _____ Phone #_____

Obstetrician / Gynecologist: _____ Phone # _____

Cardiologist: _____ Phone # _____

Other physician: _____ Phone # _____

Other physician: _____ Phone # _____

THE FOLLOWING STANDARDIZED QUESTIONNAIRES DIAGNOSE/SCREEN FOR PELVIC FLOOR DISORDERS AND MAY ADDRESS THE SAME CONDITION IN REPETITION.
PLEASE FILL THE QUESTIONNAIRES OUT ENTIRELY TO ENHANCE OUR CARE FOR WOMEN AFFECTED BY THESE SENSITIVE QUALITY-OF-LIFE DISORDERS.

1. How often do you experience urinary leakage?
   - ☐ Never
   - ☐ Less than once a month
   - ☐ A few times a month
   - ☐ A few times a week
   - ☐ Every day and/or night

2. How much urine do you lose each time?
   - ☐ Drops
   - ☐ Small splashes
   - ☐ More

INSTRUCTIONS: Following are 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 doctors understand what is important to patients about their sex lives. Please mark the box ☐ that best answers the question for you. While answering the questions, consider your sexuality over the past <u>six months</u>. Please mark only one box ☐ per question.

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 ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

2. Do you climax (have an orgasm) when having <u>sexual intercourse</u> with your partner?

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

3. Do you feel sexually excited (turned on) when having sexual activity with your partner?

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

4. How satisfied are you with the variety of sexual activities in your current sex life?

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

5. Do you feel pain during sexual intercourse?

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

6. Are you incontinent of urine (leak urine) with sexual activity?

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

7. Does fear of incontinence (either stool or urine) restrict your sexual activity?

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

8. Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum, or vagina falling out)?

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

9. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame, or guilt?

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

10. Does your partner have a problem with <u>erections</u> that affects your sexual activity?

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

11. Does your partner have a problem with <u>premature ejaculation</u> that affects your sexual activity?

☐Always ☐ Usually ☐ Sometimes ☐ Seldom ☐Never

12. Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?

☐ Much less intense ☐ Less intense ☐ Same intensity ☐More intense ☐ Much more intense

INSTRUCTIONS: Please answer these questions by putting a X in the appropriate box. If you are unsure about how to answer a question, give the best answer you can. While answering these questions, please consider your symptoms over the <u>last 3 months.</u>

1. Do you usually experience *pressure* in the lower abdomen? ⟶ ☐ No; ☐ **Yes**

   If **yes**, how much does this bother you?
   ☐ **1** Not at All - ☐ **2** Somewhat - ☐ **3** Moderately - ☐ **4** Quite a bit

2. Do you usually experience *heaviness or dullness* in the pelvic area? ⟶ ☐ No; ☐ **Yes**

   If **yes**, how much does this bother you?
   ☐ **1** Not at All - ☐ **2** Somewhat - ☐ **3** Moderately - ☐ **4** Quite a bit

3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area? ⟶ ☐ No; ☐ **Yes**

   If **yes**, how much does this bother you?
   ☐ **1** Not at All - ☐ **2** Somewhat - ☐ **3** Moderately - ☐ **4** Quite a bit

4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement? ⟶ ☐ No; ☐ **Yes**

   If **yes**, how much does this bother you?
   ☐ **1** Not at All - ☐ **2** Somewhat - ☐ **3** Moderately - ☐ **4** Quite a bit

5. Do you usually experience a feeling of incomplete bladder emptying? ⟶ ☐ No; ☐ **Yes**

   If **yes**, how much does this bother you?
   ☐ **1** Not at All - ☐ **2** Somewhat - ☐ **3** Moderately - ☐ **4** Quite a bit

6. Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination? → ☐ No; ☐ **Yes**

If **yes**, how much does this bother you?

☐ **1** ☐ **2** ☐ **3** ☐ **4**

Not at All - Somewhat - Moderately - Quite a bit

7. Do you feel you need to strain too hard to have a bowel movement? → ☐ No; ☐ **Yes**

If **yes**, how much does this bother you?

☐ **1** ☐ **2** ☐ **3** ☐ **4**

Not at All - Somewhat - Moderately - Quite a bit

8. Do you feel you have not completely emptied your bowels at the end of a bowel movement? → ☐ No; ☐ **Yes**

If **yes**, how much does this bother you?

☐ **1** ☐ **2** ☐ **3** ☐ **4**

Not at All - Somewhat - Moderately - Quite a bit

9. Do you usually lose stool beyond your control if your stool is well formed? → ☐ No; ☐ **Yes**

If **yes**, how much does this bother you?

☐ **1** ☐ **2** ☐ **3** ☐ **4**

Not at All - Somewhat - Moderately - Quite a bit

10. Do you usually lose stool beyond your control if your stool is loose or liquid? → ☐ No; ☐ **Yes**

If **yes**, how much does this bother you?

☐ **1** ☐ **2** ☐ **3** ☐ **4**

Not at All - Somewhat - Moderately - Quite a bit

11. Do you usually lose gas from the rectum beyond your control? → ☐ No; ☐ **Yes**

If **yes**, how much does this bother you?

☐ **1** ☐ **2** ☐ **3** ☐ **4**

Not at All - Somewhat - Moderately - Quite a bit

12. Do you usually have pain when you pass your stool? → ☐ No; ☐ **Yes**

If **yes**, how much does this bother you?

☐ **1** ☐ **2** ☐ **3** ☐ **4**

Not at All - Somewhat - Moderately - Quite a bit

13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement? → ☐ No; ☐ **Yes**

If **yes**, how much does this bother you?

☐ **1** ☐ **2** ☐ **3** ☐ **4**

Not at All - Somewhat - Moderately - Quite a bit

14. Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement? → ☐ No; ☐ **Yes**

If **yes**, how much does this bother you?

☐ **1** Not at All - ☐ **2** Somewhat - ☐ **3** Moderately - ☐ **4** Quite a bit

15. Do you usually experience frequent urination? → ☐ No; ☐ **Yes**

If **yes**, how much does this bother you?

☐ **1** Not at All - ☐ **2** Somewhat - ☐ **3** Moderately - ☐ **4** Quite a bit

16. Do you usually experience urine leakage associated with a feeling of urgency, that is a strong sensation of needing to go to the bathroom? → ☐ No; ☐ **Yes**

If **yes**, how much does this bother you?

☐ **1** Not at All - ☐ **2** Somewhat - ☐ **3** Moderately - ☐ **4** Quite a bit

17. Do you usually experience urine leakage related to coughing, sneezing, or laughing? → ☐ No; ☐ **Yes**

If **yes**, how much does this bother you?

☐ **1** Not at All - ☐ **2** Somewhat - ☐ **3** Moderately - ☐ **4** Quite a bit

18. Do you usually experience small amounts of urine leakage (that is, drops)? → ☐ No; ☐ **Yes**

If **yes**, how much does this bother you?

☐ **1** Not at All - ☐ **2** Somewhat - ☐ **3** Moderately - ☐ **4** Quite a bit

19. Do you usually experience difficulty emptying your bladder? → ☐ No; ☐ **Yes**

If **yes**, how much does this bother you?

☐ **1** Not at All - ☐ **2** Somewhat - ☐ **3** Moderately - ☐ **4** Quite a bit

20. Do you usually experience *pain* or *discomfort* in the lower abdomen or genital region? → ☐ No; ☐ **Yes**

If **yes**, how much does this bother you?

☐ **1** Not at All - ☐ **2** Somewhat - ☐ **3** Moderately - ☐ **4** Quite a bit

INSTRUCTIONS: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feelings. For each question, place an X in the response that best describes how much your activities, relationships or feelings have been affected by your bladder, bowel, or vaginal symptoms or conditions over the last 3 months. Please be sure to mark an answer in all 3 columns for each question.

How do symptoms or conditions relating 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 of 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
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

INSTRUCTIONS: For each of the following, please indicate on average in the past month if you experienced any amount of accidental bowel leakage: *(mark 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
GAS						
MUCUS						
LIQUID STOOL						
SOLID STOOL						

INSTRUCTIONS: Please <u>mark</u> an "X" in the box for the answer that best describes how you feel for each question.

1. How many times do you go to the bathroom during the day?

☐3-6 ☐ 7-10 ☐11-14 ☐ 15-19 ☐20+

2a. How many times do you go to the bathroom at night?

☐0 ☐1 ☐ 2 ☐ 3 ☐ 4+

b. If you get up at night to go to the bathroom does it bother you?

☐Never ☐Mildly ☐Moderate ☐ Severe

3. Are you currently sexually active?

☐Yes ☐ No

4a. IF YOU ARE SEXUALLY ACTIVE, do you now or have you ever had pain or symptoms during or after sexual intercourse?

☐ Never ☐ Occasionally ☐ Usually ☐ Always

b. **If you have pain**, does it make you avoid sexual intercourse?

☐ Never ☐ Occasionally ☐ Usually ☐ Always

5. Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum)?

☐ Never ☐ Occasionally ☐ Usually ☐ Always

6. Do you have urgency after going to the bathroom?

☐ Never ☐ Occasionally ☐ Usually ☐ Always

7a. **If you have pain**, is it usually

☐ Mild ☐ Moderate ☐ Severe

b. Does your pain bother you?

☐ Never ☐ Occasionally ☐ Usually ☐ Always

8a. **If you have urgency**, is it usually

☐ Mild ☐ Moderate ☐ Severe

b. Does your urgency bother you?

☐ Never ☐ Occasionally ☐ Usually ☐ Always

Physician signature _____ Date: _____

☐Tirsit S. Asfaw, M.D.

☐Saya Segal, MD. MSCE

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