



# PIONEER VALLEY

## UROLOGY, P.C.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### New Patient History Form

### FEMALE

Chief Complaint (Why do you want to see the doctor today?):

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#### Incontinence/Pelvic Floor Questionnaire

(Fill in and Circle answers)

#### BLADDER

How many times do you urinate during the day: \_\_\_\_\_ During the night? \_\_\_\_\_

Is the amount of urine that you void a:

- Large Amount
- Average Amount
- Small Amount

Do you experience incontinence (leakage of urine) with any of the following activities?

|          |       |          |       |                       |       |
|----------|-------|----------|-------|-----------------------|-------|
| Coughing | Y / N | Exercise | Y / N | Sexual Activity       | Y / N |
| Laughing | Y / N | Bending  | Y / N | Standing from sitting | Y / N |
| Sneezing | Y / N | Sleeping | Y / N |                       |       |

Some women have a very sudden overwhelming desire to urinate with very little warning and fear that they will leak urine if they do not get to the bathroom in time.

|   |                                     |
|---|-------------------------------------|
| How often does this happen to you?              | Never / Rarely / Sometimes / Always |
| Can you overcome this strong desire to urinate? | Never / Rarely / Sometimes / Always |

If you do experience urgency (desperate desire to urinate), do you lose urine before making it to the toilet? Y / N

If YES, how often does this happen to you? Never / Rarely / Sometimes / Always

Do you lose urine when you suddenly feel that your bladder is full? Y / N

Do you lose urine with:

|                                      |       |              |       |                        |       |
|--------------------------------------|-------|--------------|-------|------------------------|-------|
| Handwashing                          | Y / N | Cold Weather | Y / N | Drinking cold beverage | Y / N |
| Key in the door when you return home | Y / N |              |       |                        |       |

How many protective pads do you use per day for protection? \_\_\_\_\_

*Expert, compassionate care for all your genitourinary needs.*



# PIONEER VALLEY

## UROLOGY, P.C.

Do you have frequent urinary tract infections (UTI)? Y / N

If YES, how many UTI's in the past year? \_\_\_\_\_

Do you ever see blood in your urine? Y / N

How would you describe your urine flow when you void? Strong / Weak / Dribbling / Intermittent

Do you feel that you empty your bladder completely when you urinate? Y / N

Do you have to assume abnormal positions to urinate? Y / N

Do you have difficulty initiating urination once you sit on the toilet? Y / N

Is your urine flow continuous once you begin voiding or does it start and stop (intermittency)?

Continuous / Start/Stop

Do you ever have pain with urination? Y / N

Do you ever have pain your lower abdomen or pelvic area? Y / N

If YES, is the pain related to any of the following:

Your bladder being full Y / N

Your menstrual cycle Y / N

Sexual Intercourse Y / N

Bowel Movements Y / N

Have you had a history of incontinence as a child? Y / N

Have you had a history of bed-wetting as a child? Y / N

### PROLAPSE

Do you usually experience pressure in the lower abdomen? Y / N

Do you usually experience heaviness or dullness in the pelvic area? Y / N

Do you experience a feeling of incomplete bladder emptying? Y / N

Do you usually have a bulge or something falling out that you can see or feel in your vaginal area? Y / N

Do you ever have to push on the vagina or around the rectum to have or complete a bowel movement? Y / N

Do you ever have to push up on a bulge in the vaginal are with your fingers to start or complete urination? Y / N

Do you feel that you need to strain too hard to have a bowel movement? Y / N

Do you feel that you have not emptied you bowels at the end of a bowel movement? Y / N

Do you usually lose control of your stool? Y / N

Do you usually lose control of gas from the rectum? Y / N

Do you ever have pain when you pass your stool? Y / N

Are you currently sexual active? Y / N

Is sexual activity an important consideration in how we manage your problem? Y / N

### GYN

Number of pregnancies: \_\_\_\_\_ Number of Vaginal births: \_\_\_\_\_ History of episiotomy/laceration: Y / N

When was your last menstrual period? \_\_\_\_\_

If you are still menstruating, are you periods:

Regular / Irregular

Heavy / Average / Light

Painful: Y / N

Are you having abnormal vaginal discharge or discomfort? Y / N

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# PIONEER VALLEY UROLOGY, P.C.

Are you taking hormones (Estrogen/Progestin's)? Y / N

If yes, please list:

Hormonal replacement therapy \_\_\_\_\_

Oral contraceptive \_\_\_\_\_

Vaginal estrogen creams \_\_\_\_\_

When was you last Pap smear? \_\_\_\_\_

Have you had your uterus removed (Hysterectomy)? Y / N

Have you had you ovaries removed (Oophorectomy)? Y / N

### QUATLITY OF LIFE IMPACT

How do your symptoms related to your urinary condition affect you ability to perform the following:

- Household chores (cooking, cleaning, laundry)?
- Physical recreation such as walking, swimming, other exercise?
- Participate in activities (church, movies, concerts)?
- Travel more than 30 minutes from home?
- Participate in social activities outside your home?
- Participate and enjoy sexual activity?

| Not at all | Minimal | Mild | Moderate | Severe |
|------------|---------|------|----------|--------|
| 0          | 1       | 2    | 3        | 4      |
| 0          | 1       | 2    | 3        | 4      |
| 0          | 1       | 2    | 3        | 4      |
| 0          | 1       | 2    | 3        | 4      |
| 0          | 1       | 2    | 3        | 4      |
| 0          | 1       | 2    | 3        | 4      |