Premier Urogynecology of North Texas
Patient Intake Questionnaire
Patient's Name: _____
Referring Physician's Name : _____ Address: _____
Primary Physician (PCP):_____Address:_____
Additional Provider _____ Address: _____

To help provide you with the best care, please complete this form in as much detail as possible. **Please bring the completed form with you at the time of your visit.**

I. CHIEF COMPLAINT

Briefly write in your own words the nature of your current problem. Thank you!

_____

_____

PHYSICIAN NOTES: (PLEASE DO NOT WRITE IN THIS SPACE)

Vaginal	Urine	Bowel

II. PREGNANCY HISTORY

Total number of Pregnancies _____
Number of vaginal birth (s) _____ Number of cesarean (s) _____
Were these ever used during any of your deliveries? ___ Forceps ___ Vacuum
Number of miscarriage(s) or abortion(s) _____
Size of your largest baby _____
Complications: ___ No ___ Yes; If yes, please specify what_____

III. GYNECOLOGIC HISTORY

-Age when your periods first started _____ Interval _____ days Duration _____ days
-Date of your last menstrual period _____
-Have you gone through menopause (the change)? ___ No ___ Yes
If yes, how old were you? _____
-Date of last pap smear _____
-Have you ever had abnormal pap smears? ___ No ___ Yes
-Any cancer of the Breast, Ovary, Uterus, or Cervix? (if yes, circle) ___ No ___ Yes
If yes, how old were you? _____
-Have you been sexually active in the past year? ___ No ___ Yes
-Any pain with sexual intercourse? ___ No ___ Yes
-Do you have any of the following symptoms *now*?
___ Vaginal Discharge ___ Vaginal Bleeding ___ Heavy Periods ___ Painful Periods

IV. PAST MEDICAL HISTORY

As an adult, have you ever been told by your doctor that you have (check all that apply):

___ Heart Disease
___ Heart Murmur
___ Parkinson's
___ Alzheimer's
___ Multiple Sclerosis
___ Paralysis
___ Stroke
___ Disc Disease
___ Spinal Cord Disease
___ High Blood Pressure
___ Diabetes
___ High Cholesterol
___ Asthma
___ COPD
___ Thyroid Disease
___ Arthritis
___ Depression
___ Cancer, please specify _____
___ Glaucoma
___ Blood Clots
___ Prolonged Bleeding
___ Irritable Bowel (IBS)
___ Kidney Disease
___ Kidney Stones
___ Hepatitis
___ HIV or AIDS
___ Any bladder problems growing up? Please specify _____
___ Other _____

V. PAST SURGERY HISTORY

Please list type and date of all your surgeries you have had (continue on other side if needed):

Date	Operation	Hospital/Physician?	Complications?

Any problems with Anesthesia? ___ No ___ Yes

If yes, please explain: _____

VI. PAST HOSPITALIZATION HISTORY

Please list type and date of all your hospitalizations: (continue on other side if needed):

Date	Operation	Hospital/Physician?	Complications?

VII. CURRENT MEDICATIONS (continue on other side if you run out of room)

Name of Medicine	Dosage	How often do you take it?

VII. ALLERGIES (continue on other side if needed)

Do you have any drug allergy (ies) ___ No ___ Yes

If yes, which drug(s) and what kind of reaction? _____

_____

IX. SOCIAL HISTORY

Current marital status? _____ Your occupation? _____

City and state where you currently live: _____

Any heavy lifting at work or at home? ___ No ___ Yes

Do you exercise regularly? ___ No ___ Yes

Any history of street drugs? ___ No ___ Yes

Do you currently smoke? ___ No ___ Yes

Number of cigarettes a day _____ and a number of years _____

Have you quit smoking? ___ No ___ Yes; if yes, when? _____

Do you drink alcohol? ___ No ___ Yes; how much per day? _____

Do you drink coffee, tea, or soda? ___ No ___ Yes; how much per day? _____

X. FAMILY HISTORY

Does anyone in your related immediate family have any of the following (check only if yes)

Heart disease	___	Hypertension	___	Stroke	___
Diabetes	___	Arthritis	___	Pelvic Prolapse	___
Incontinence	___	Clotting Disorder	___	Seizures	___
Psychiatric Disorder	___	Obesity	___	Breast Cancer	___
Ovarian Cancer	___	Uterine Cancer	___	Colon Cancer	___

Other cancer ___ (Type?) _____

CURRENT COMPLAINTS (Review of Systems)

Do you currently have any of these symptoms?

General	No	Yes	Eyes, Ears, Nose & Throat	No	Yes
Weight Loss	___	___	Visual Problems	___	___
Weight Gain	___	___	Hearing Problems	___	___
Fevers/chills	___	___	Nose Bleeds	___	___
Frequent Night Sweats	___	___	Sinus Problems	___	___
Excessive fatigue	___	___	Sore Throat	___	___

Endocrine	No	Yes	Respiratory	No	Yes
Intolerance to Heat	___	___	Shortness of Breath	___	___
Intolerance to Cold	___	___	Chronic Cough	___	___
Abnormal Thirst	___	___	Wheezing	___	___
Abnormal Hair Growth	___	___	Chest Pain	___	___

Cardiovascular	No	Yes	Gastrointestinal	No	Yes
Limited Exercise Tolerance	___	___	Blood in Stools	___	___
Palpitations	___	___	Frequent Heartburn	___	___
Leg Swelling	___	___	Abdominal Pain	___	___
Varicose Veins	___	___	Diarrhea	___	___
			Constipation	___	___

PLEASE GIVE PATIENT QOL QUESTIONNAIRES

CURRENT COMPLAINTS (Review of Systems) – Continued

Urinary	No	Yes
Do you leak urine?	___	___
Any blood in the urine?	___	___
Is it difficult to urinate?	___	___
Any bulge in the vagina?	___	___

Skin	No	Yes
Itching	___	___
Rash	___	___
New Moles or Lesions	___	___

Neurologic	No	Yes
Migraine Headaches	___	___
Numbness of Limbs	___	___
Frequent Dizziness	___	___
Memory Loss	___	___

Musculoskeletal	No	Yes
Joint Stiffness	___	___
Joint Pain	___	___
Joint Swelling	___	___
Back Pain	___	___

Hematologic	No	Yes
Easy Bruising	___	___
Bleeding Gums	___	___
Prolonged Bleeding	___	___
Clotting Problems	___	___

Psychosocial	No	Yes
Difficulty Sleeping	___	___
Anxiety or Panic Attacks	___	___
Depression	___	___

ADDITIONAL QUESTIONS ABOUT URINARY LEAKAGE (INCONTINENCE) AND YOUR BLADDER:

How long have you had significant urinary leakage? _____ (state "0" if none)

What do you use for protection when you leak?

___ Nothing
___ Light or thin (pantyliner)
___ Regular pads
___ Heavy pads
___ Diapers/Incontinence briefs
___ Towels or I just change clothes

If you use protection, how many on average do you use each day? _____

-Do you lose urine while you are still asleep? ___ No ___ Yes
-Do you dribble urine right after emptying your bladder? ___ No ___Yes
-Have you ever had blood in your urine? ___ No ___ Yes
If yes, how many in the past year? _____
-Do you have burning when you urinate today? ___ No ___ Yes
-Did you have trouble holding urine as a child (bedwetting)? ___ No ___ Yes
-Have you ever seen a Urologist before? ___ No ___ Yes
-Have you ever been diagnosed with intestinal cystitis? ___ No ___ Yes
-Have you had dilation (stretching) of the urethra? ___ No ___ Yes