First Coast Urogynecology & Center for Pelvic Floor Health – History Form

Today's Date: _____ Your Name: _____
Birth Date:_____ Age:_____

Why are you seeing the doctor?_____
Pelvic Floor Questions: (please answer yes or no)
Pelvic Organ Prolapse (Bulge in vagina) **Yes/No**
Do you push in your vagina to help you urinate or have a bowel movement? **Yes/No**
Urinary Leakage? **Yes/No** Do you have problems emptying your bladder? **Yes/No**
How many times do you urinate at night? _____ during the day? _____
Do you have constipation? **Yes/No** Fecal incontinence (stool leakage)? **Yes/No**
Are you sexually active? **Yes/No** Do you have pain during intercourse? **Yes/No**

Medical History: <u>Do you have, or are you being treated for</u>, any of the following problems?

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Attack, year _____
- ☐ Heart Disease, explain _____
- ☐ Atrial Fibrillation
- ☐ Stroke
- ☐ Asthma
- ☐ COPD (chronic bronchitis or emphysema)
- ☐ Hypothyroid (low thyroid level)
- ☐ Hyperthyroid (high thyroid level)
- ☐ Kidney Failure
- ☐ Breast or Ovarian Cancer
- ☐ Other Cancer, explain _____
- ☐ Irritable Bowel Syndrome
- ☐ Gastric Reflux
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Anxiety
- ☐ Chronic Pain Issues
- ☐ Back Pain Issues
- ☐ Glaucoma (open angle/closed angle)
- ☐ Multiple Sclerosis
- ☐ Seizure Disorder
- ☐ Neurologic Disease, explain _____
- ☐ History of DVT or Pulmonary Embolism
- ☐ Other_____

Surgical History: (**Please check box if yes** and circle related questions)

- ☐ Hysterectomy (removal of uterus) Surgical approach: Abdominal/Vaginal/Laparoscopic
- ☐ Removal of Ovaries
- ☐ Incontinence Surgery Surgical approach: Abdominal/Vaginal Mesh used:Yes/No
- ☐ Pelvic Prolapse Surgery Surgical approach: Abdominal/Vaginal Mesh used:Yes/No
- ☐ Abdominal Surgery Surgical incision: Vertical/Transverse/Laparoscopic
  explain:_____
- ☐ Other Surgery, explain

_____
_____
_____

Gynecology/Obstetrical History:
Last Menstrual Period or year of menopause _____

Last Pap Smear _____ (Normal/Abnormal)
Number of pregnancies (Gravida)_____ Number of live births (Parity) _____

Social History:

Do you use tobacco? **Yes/No** If yes, daily amount _____
Do you drink alcoholic beverages? **Yes/No** If yes, daily amount _____
Do you drink caffeinated beverages? **Yes/No** If yes, daily amount _____
Are you a victim of sexual/domestic abuse? **Yes/No** Are you in current danger? **Yes/No**
Do you use illegal drugs? **Yes/No** If yes, which _____
Marital status? _____ Race? _____
Language? _____ Ethnicity? _____

Screening History:

Colorectal Screening if 50-75yo: Colonoscopy- **Yes/No**, Last Colonoscopy_____
Flu Shot: **Yes/No**, when_____
Pneumonia Vaccine (Pneumovax) if 65yo or older: **Yes/No**, when _____
Osteoporosis if 65yo or older: Have you had bone density testing? **Yes/No,** when _____
Mammography if 40-69yo: Have you had a mammogram **Yes/No**, when _____

Family History: (If yes, then indicate family members relationship to you)

Ovarian Cancer	Yes/No	_____
Breast Cancer	Yes/No	_____
Neurologic or Inherited Disease	Yes/No	_____

Medications: (Please list all medications with the dose)

□ Blood Thinners (Coumadin/Warfarin/Pradaxa/Arixtra/Plavix/Aspirin/_____)
□ Blood Pressure/Heart Medication _____
□ Thyroid Medicine (synthroid/armour thyroid/_____)
□ Hormone or Birth Control _____
□ Other medications

_____
_____
_____

Allergies: Are you allergic to any medications? **Yes / No** (If yes, please list the medication(s) and the type(s) of reactions to them).

_____
_____

Please Do Not Write Below This Line

First Coast Urogynecology & Center for Pelvic Floor Health – Review of Systems

Please circle if you experience any of the following

General

- ☐ Loss of appetite
- ☐ Chills
- ☐ Fever
- ☐ Unintentional weight loss >10 lbs

Skin

- ☐ Boils
- ☐ Rash
- ☐ Itching

HEENT

- ☐ Worrisome vision changes
- ☐ Worrisome hearing changes
- ☐ Sinus problems

Respiratory

- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Chronic cough

Cardiovascular

- ☐ Chest pain
- ☐ Difficulty breathing on with prolonged activity

Gastrointestinal

- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Heartburn

Female Genitourinary

- ☐ Pelvic pain
- ☐ Vaginal discharge
- ☐ Blood in urine
- ☐ Flank pain
- ☐ Painful urination
- ☐ Weak or prolonged urinary stream

Musculoskeletal

- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Back pain

Neurological

- ☐ Headaches
- ☐ Loss of vulvar sensation
- ☐ New weakness in your legs

Psychiatric

- ☐ Severe depression
- ☐ Hallucinations

Hematology

- ☐ Bleeding problems requiring Hematologist
- ☐ History of blood clots
- ☐ History of easy bleeding