

Patient Label _____

Patient Medical History – Adult Female

Height _____ Weight _____

Telephone number where patient contacted: (H) _____ (W) _____ (Cell) _____

Who referred you for this consultation? (Self? Doctor? If so, from what clinic?) _____

Emergency contact person: Name _____ Phone _____

Describe the location/symptom/problem that is the reason for your visit: _____

Please mark on the line the severity of your problem: 01.....2.....3.....4.....5.....6.....7.....8.....9.....10
 None Moderate Severe

When did this problem start? _____

Does anything make this problem better or worse? Please describe: _____

Are there other associated problems? No Yes If yes, describe _____

UDI-6 Urogenital Distress Inventory

Do you experience the following? If so, how much are you bothered by:	NOT AT ALL	SLIGHTLY	MODERATELY	GREATLY
Frequent urination?	0	1	2	3
Urine leakage related to the feeling of urgency? (sudden desire to urinate)	0	1	2	3
Urine leakage related to physical activity, coughing or sneezing?	0	1	2	3
Small amounts of urine leakage (drops)?	0	1	2	3
Difficulty emptying your bladder?	0	1	2	3
Pain or discomfort in the lower abdominal or genital area?	0	1	2	3

Symptom Score _____

IIQ-7 Incontinence Impact Questionnaire

Over the past month has the leakage of urine and/or prolapse affected:	NOT AT ALL	SLIGHTLY	MODERATELY	GREATLY
your ability to do household chores (cooking, housecleaning)?	0	1	2	3
your physical recreation such as walking, or other exercise?	0	1	2	3
your ability to attend entertainment activities (movie, concerts)?	0	1	2	3
your ability to travel by car more than 30 minutes from home?	0	1	2	3
your participation in social activities outside your home?	0	1	2	3
your emotional health (nervousness, depression, etc)?	0	1	2	3
made you feel frustrated?	0	1	2	3

Bother Score _____

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that? Circle the number that best reflects your feelings about your urinary problem.

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
 Pleased Indifferent Terrible

QOL Score _____

PAST MEDICAL, FAMILY AND SOCIAL HISTORY

Are you or a blood **relative** having problems (now or in the past) with any of the following? No Yes
If yes, please check all boxes that apply.

Have you had **surgery** on any of the following?
 No Yes
If yes, please check all boxes that apply.
INCLUDE SURGERY DATE:

	You	Family Member
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Type of cancer: _____		
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
GERD / Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Gout (high uric acid)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Toxic Exposure	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Other/Explain:	<input type="checkbox"/>	<input type="checkbox"/>

Appendix	<input type="checkbox"/>
Back	<input type="checkbox"/>
Bladder	<input type="checkbox"/>
Breast	<input type="checkbox"/>
Colon	<input type="checkbox"/>
Gallbladder	<input type="checkbox"/>
Heart Bypass	<input type="checkbox"/>
Heart Valve	<input type="checkbox"/>
Hernia	<input type="checkbox"/>
Hysterectomy	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>
Kidney	<input type="checkbox"/>
Lung	<input type="checkbox"/>
Pelvic Laparoscopy	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>
Total Joint Replacement	<input type="checkbox"/>
Right: <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Shoulder	
Left: <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Shoulder	
Urethra	<input type="checkbox"/>
Other/Explain:	<input type="checkbox"/>

Have you ever had MRSA? No Yes
Positive Mantoux/PPD? No Yes
Do you have any medication allergies?
 No Yes If yes, please list:
Latex allergy? No Yes

Could you be pregnant? No Yes

Do you have children? No Yes

of pregnancies _____
_____ Vaginal _____ Caesarean

Do you or did you ever smoke? No Yes
If yes:
How many packs per day? _____

How many years? _____
When did you quit? _____

Do you drink alcohol? No Yes
If yes, how much? _____

Are you on a special diet? No Yes
If yes, explain: _____

Are you married? No Yes
 Divorced
 Widowed

Are you employed? No Yes

What is your occupation?

Allergy	Type of Reaction (rash, nausea, etc.)

Physician use only: (Comments/Notes)

Physician Signature: _____ **Date:** _____