The Methodist Hospital
Center for Restorative Pelvic Medicine

MEDICAL QUESTIONNAIRE

Dear Patient:

Please take a few minutes to complete this form. This will help assure you of the best possible care and will be held in confidence as part of your medical record. Information contained here will not be released to anyone without your authorization to do so.

Name: _____ _____ _____ **Today's Date:** _____
Last First M.I.

Age: _____ **Date of Birth** ____/____/____ **Occupation:** _____
M D Y

Referring Doctor: _____ **Primary Care Doctor:** _____

Please write in your own words the nature of your problem and reason for your visit: _____
_____

List any current or prior **medical problems/illnesses**:

☐ High blood pressure	☐ Heart disease	☐ Stroke
☐ High cholesterol	☐ Diabetes	☐ Thyroid disease
☐ Arthritis	☐ Liver disease	☐ Reflux/Indigestion
☐ Anxiety or Depression	☐ Heart Murmur	☐ Asthma
☐ Liver disease	☐ Cancer, list type: _____	

List Other Medical Illnesses
_____
_____
_____

List all **surgical procedures** you have had and the approximate year of treatment:

	Month/Year of Surgery	Other Surgical Procedures	Month/Year of Surgery
☐ Hysterectomy	_____	_____	
☐ Urinary Incontinence (leakage) Repair	_____	_____	
☐ Prolapse or Vaginal lift/bladder Lift Procedure	_____	_____	
☐ Back Surgery	_____	_____	
☐ Bowel Surgery	_____	_____	

List all **Medications** you are taking and **Dosage** (Include non-prescription drugs):

_____ _____
_____ _____
_____ _____

List all **Medication Allergies** and type of reaction**:** _____
_____

Physician use only: (Comments/Notes)

I have reviewed the Medical Questionnaire with the patient. _____ _____
Physician Signature Date

OB/GYN HISTORY

How many times have you been pregnant? _____

How many children did you deliver? _____

List number of: Vaginal deliveries ___ C-sections ___

Miscarriages ___ Abortions ___ Ectopic pregnancy ___

Weight of largest child at birth: _____

Did you have an episiotomy or tear into the rectum? Yes ___ No __

Have you gone through menopause? Yes ____ No ____

If yes, at what age? _____

If yes, are you taking hormone replacement Yes ____ No ____

Type of hormone replacement _____

Have you had any bleeding since menopause? Yes ____ No ___

Date of last menstrual period _____

If still having periods:

Is bleeding light, moderate, or heavy _____

How many days does period last _____

Are your periods regular? Yes _____ No _____

Do you have severe menstrual cramping? Yes _____ No _____

Birth control method: _____

Date of last PAP smear _____

Was the last PAP normal? Yes _____ No _____

Have you ever had an abnormal pap smear or treatment on your cervix? Yes _____ No _____

If yes, Explain: _____

Date of last mammogram _____

Was the last mammogram normal? Yes _____ No _____

Have you ever had a sexually transmitted infection?

Yes _____ No _____ If yes, list type: _____

Do you have sexual relations with a partner? Yes ____ No ____

How long have you been with your current sexual partner? _____

Is your sex life satisfactory to you? Yes ____ No ____

Do you have pain with sexual intercourse? Yes ____ No ____

Have you been a victim of domestic violence or sexual abuse?

Yes _____ No _____

SOCIAL HISTORY

Current marital status: Married ____ Single ____ Divorced ____

Widowed ____ Separated ____

Number of people living in your household: _____

Do you smoke now or in the past? Yes ____ No ____

Packs per day? _____ Years smoked? _____

If you have quit, please indicate year _____

Do you exercise regularly? Yes _____ No _____

If yes, what type of exercise do you do? _____

_____

Do you drink alcoholic beverages? Yes _____ No _____

Explain: _____

Do you have a history of drug use? Yes _____ No _____

FAMILY HISTORY

	Still Alive		Age Now or at Time of Death	Cause of Death	Have they had any major illnesses? Please indicate for each relative.
	YES	NO			
Mother	☐	☐			
Father	☐	☐			
Brother(s)	☐	☐			
Sister(s)	☐	☐			

Physician use only: (Comments/Notes)

I have reviewed the Medical Questionnaire with the patient. _____ _____

Physician Signature Date

PATIENT NAME _____ ☐ NPV ☐ ROV DATE _____

UROGYNECOLOGY HISTORY

Do you have bladder control problems such as:

□ Leaking urine with exertion (coughing, laughing, sneezing, climbing stairs, exercising). If so, for how long? _____

□ Leaking urine on the way to the bathroom, with a sudden strong urge. If so, for how long? _____

□ Strong urge to urinate □ Dribbling urine

□ Pain or burning when you urinate □ Blood in your urine

□ Difficulty starting the stream of urine □ Frequent bladder infections

On average, how often to you urinate during the day? ____ times

How often do you awaken to urinate at night? _____ times

Do you ever wet the bed? Yes ____ No ____

Do you use pads for urinary leakage? Yes _____ No _____

If yes, what type of pad _____

How often do you change your pad per day? _____

Do you have pain or pressure in the vagina? Yes ____ No ____

Frequency of bowel movements _____ /day; _____ /week

Have you had a colonoscopy? Yes _____ No _____ Date of last: _____ Result: _____

Do you have problems with: □ Constipation □ Diarrhea □ Change in bowel habits □ Anal/rectal bleeding

Do you have fecal incontinence or leak stool? Yes _____ No _____ If yes, for how long? _____

Do you leak solid stool? _____ Liquid stool? _____ Gas? _____

GOALS

What are your goals for this consultation? _____

_____

What do you hope to be able to do after treatment that you are having difficulty doing? _____

PELVIC FLOOR IMPACT QUESTIONNAIRE

(Please answer: not at all, somewhat, moderately, or quite a bit)

How do symptoms or conditions relate to the following? → *Usually affect your*	Bladder or Urine	Bowel or Rectum	Vaginal or Pelvis
1. Ability to do household chores (cooking, housecleaning, laundry)?			
2. Ability to do physical activities such as walking, swimming, or other exercise?			
3. Entertainment activities such as going to a movie or concert?			
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?			
5. Participate in social activities outside your home?			
6. Emotional health (nervousness, depression, etc)?			
7. Feeling frustrated?			

Physician use only: (Comments/Notes)

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Physician Signature Date

PATIENT NAME _____ □ NPV □ ROV DATE _____

PELVIC FLOOR IMPACT QUESTIONNAIRE

Do you now or have you had problems with any of the following?

	No	If yes, how much does it bother you?			
		Not at all	Somewhat	Moderately	Quite a bit
PELVIC ORGAN PROLAPSE DISTRESS					
1. Usually experience *pressure* in the lower abdomen?	0	1	2	3	4
2. Usually experience *heaviness* or *dullness* in the pelvic area?	0	1	2	3	4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1	2	3	4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1	2	3	4
5. Usually experience a feeling of incomplete bladder emptying?	0	1	2	3	4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1	2	3	4
COLORECTAL-ANAL DISTRESS					
7. Feel you need to strain too hard to have a bowel movement?	0	1	2	3	4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1	2	3	4
9. Usually lose stool beyond your control if your stool is well formed?	0	1	2	3	4
10. Usually lose stool beyond your control if your stool is loose or liquid?	0	1	2	3	4
11. Usually lose gas from the rectum beyond your control?	0	1	2	3	4
12. Usually have pain when you pass your stool?	0	1	2	3	4
13. Experience a strong sense of urgency to have to rush to the bathroom to have a bowel movement?	0	1	2	3	4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1	2	3	4
URINARY DISTRESS					
15. Usually experience frequent urination?	0	1	2	3	4
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of need to go to the bathroom?	0	1	2	3	4
17. Usually experience urine leakage related to coughing, sneezing, or laughing?	0	1	2	3	4
18. Usually experience small amounts of urine leakage (that is, drops)?	0	1	2	3	4
19. Usually experience difficulty emptying your bladder?	0	1	2	3	4
20. Usually experience *pain* or *discomfort* in the lower abdomen or genital region?	0	1	2	3	4

Physician use only: (Comments/Notes)

I have reviewed the Medical Questionnaire with the patient. _____ _____

Physician Signature Date

PATIENT NAME _____ ☐ NPV ☐ ROV DATE _____

REVIEW OF SYMPTOMS

Please check if any of the following symptoms apply:

Constitutional Symptoms
___fever
___chills
___loss of appetite
___weight loss
___weight gain
___other_____

Gastrointestinal
___nausea
___vomiting
___abdominal pain
___black stools
___indigestion/heartburn
___other_____

Endocrine
___too cold
___too hot
___excessive thirst
___fatigue
___other_____

Eyes
___blurred vision
___double vision
___eye pain
___other_____

Genitourinary
___vaginal discharge
___kidney stones
___other_____

Hematologic/Lymphatic
___easy bruising
___bleeding
___swollen glands
___anemia/low blood count
___other_____

Ear/Nose/Throat
___ear pain
___ringing in ears
___decreased hearing
___frequent bloody noses
___sore throat
___other_____

Musculoskeletal
___neck pain
___back pain
___joint pain
___difficulty walking
___other_____

Allergic/Immunologic
___hives
___hay fever
___other_____

Breast
___breast lump
___nipple discharge
___breast pain
___other_____

Skin
___skin rash
___persistent itching
___change in any mole
___other_____

Cardiovascular
___chest pain
___palpitations
___passing out/loss of consciousness
___swelling in legs
___other_____

Neurologic
___weakness
___numbness/tingling
___seizures
___passing out/loss of consciousness
___tremors
___headaches
___other_____

Respiratory
___cough
___shortness of breath
___coughing up blood
___wheezing
___other_____

Psychiatric
___depression
___anxiety
___psychiatric treatment
___other_____

Physician use only: (Comments/Notes)

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BLADDER DIARY

- You may start the diary any day of the week, but please use it for 2 days in a row.
- Record the amount of fluid you drink each hour of the day in ounces or milliliters and the type of fluid (example coffee, tea, soda, etc).
- Record each time you urinate by placing an **X** in the Toilet column next to the corresponding time.
- Record each time you accidentally lose urine, even if only a small amount, by placing an X in the Accident column next to the corresponding time each day.
- If needed, you can place more than one **X** in each box.
- For each day, write in the time when you get up, the time you go to bed and the number of pads you used at the bottom of the column.

	Day 1 Date ___/___/___			**Day 2** Date ___/___/___		
TIME	Fluid Intake	Toilet	Accident	Fluid Intake	Toilet	Accident
12-12:59 am						
1-1:59 am						
2-2:59 am						
3-3:59 am						
4-4:59 am						
5-5:59 am						
6-6:59 am						
7-7:59 am						
8-8:59 am						
9-9:59 am						
10-10:59 am						
11-11:59 am						
12-12:59 pm						
1-1:59 pm						
2-2:59 pm						
3-3:59 pm						
4-4:59 pm						
5-5:59 pm						
6-6:59 pm						
7-7:59 pm						
8-8:59 pm						
9-9:59 pm						
10-10:59 pm						
11-11:59 pm						
# Pads used						
Time woke up						
Time went to bed						

Physician use only: (Comments/Notes)

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Physician Signature Date

PATIENT NAME _____ □ NPV □ ROV DATE_____