New Patient Questionnaire

PATIENT INFORMATION

Last name _____ First name _____

Date of birth _____ Age _____ Date of appointment _____

Referring physician _____ Their city / practice _____

How did you hear about us? (friend, my doctor, web search, directory, previous patient)

_____

Chief complaint — why you came in today

_____

1 · BLADDER CONTROL — LEAKAGE, URGENCY, FREQUENCY

Do you have accidental loss of urine, or urinary urgency / frequency? ☐ Y ☐ N

If no, skip to section 2.

How long? (months) _____ or (years) _____ Daytime bathroom trips _____ Times up at night _____

Do you wear pads for lost urine? ☐ Y ☐ N How many/day _____

Do you wet the bed while asleep? ☐ Y ☐ N

Can't make it to the bathroom in time? ☐ Y ☐ N

Does running water trigger loss? ☐ Y ☐ N

Glasses of liquid per day _____ Caffeinated drinks per day _____

Have you had surgery for leakage? ☐ Y ☐ N

Have you seen another physician about this? ☐ Y ☐ N Who _____

Taken medication to prevent loss? ☐ Y ☐ N What _____

2 · BLADDER EMPTYING

Do you have trouble emptying your bladder? ☐ Y ☐ N

If no, skip to section 3.

Do you have to strain or push to start? ☐ Y ☐ N

Is your stream weak or interrupted? ☐ Y ☐ N

Do you feel you have not fully emptied? ☐ Y ☐ N

Do you have to go again soon after going? ☐ Y ☐ N

Have you ever needed a catheter? ☐ Y ☐ N

3 · PROLAPSE / VAGINAL SUPPORT

Do you feel a bulge, pressure, or heaviness in the vagina? ☐ Y ☐ N

If no, skip to section 4.

Is it worse at the end of the day or on standing? ☐ Y ☐ N

Do you have to push it back to empty your bladder or bowels? ☐ Y ☐ N

Have you ever used a pessary? ☐ Y ☐ N

Have you had surgery to repair prolapse? ☐ Y ☐ N Year _____

4 · BOWEL SYMPTOMS

Do you have problems with your bowels — leakage or difficulty emptying? ☐ Y ☐ N

If no, skip to section 5.

How long? (months) _____ or (years) _____ Episodes per week _____

Accidental loss of solid stool? ☐ Y ☐ N

Accidental loss of liquid stool? ☐ Y ☐ N

Accidental loss of gas? ☐ Y ☐ N

Do you wear protective pads? ☐ Y ☐ N How many/day _____

Do you strain to move your bowels? ☐ Y ☐ N

5 · SEXUAL HISTORY

Are you sexually active? ☐ Y ☐ N

If not active, are barriers due to prolapse, incontinence, or pain?

_____

6 · PELVIC PAIN

Do you have pain in your pelvic area? ☐ Y ☐ N

If no, you are finished — thank you.

Where is the pain? (pelvic area, vagina, rectum, bladder) _____ How long? _____

Is the pain worse when your bladder is full? ☐ Y ☐ N

Is it better after you empty your bladder? ☐ Y ☐ N

Does it interfere with daily activities? ☐ Y ☐ N

Thank you. There is nothing here you have to answer if you would rather discuss it in person.