FW
Fort Worth Urogynecology
UROGYNECOLOGY & RECONSTRUCTIVE PELVIC SURGERY
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New Patient Questionnaire

✓ Patient Information

Last name _____ First name _____

Date of birth mm/dd/yyyy Age _____

Date of appointment mm/dd/yyyy 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

Do you have accidental loss of urine, or urinary urgency/frequency? Yes No

How long? _____ months _____ years

Do you use pads for lost urine? Yes No If yes, how many pads per day? _____

Bathroom trips during the day? _____ Times you wake at night to go? _____

Ever wet the bed while asleep? Yes No Times you can't make it in time? Yes No

Does running water trigger loss? Yes No

Which best describes your urine loss? *(check all that apply)*

I lose urine with coughing, sneezing, running, or lifting | I lose urine with changes in posture, standing, or walking | I lose urine continuously — I am constantly wet | I have a sudden, urgent need without making it to the bathroom

Glasses of liquid daily? _____ Caffeinated drinks daily? (coffee, tea, soda) _____

Have you seen a physician for urine loss? Yes No If yes, who? _____

Surgery for urinary leakage? Yes No Taken medication to prevent urine loss? Yes No

If yes, what medication? _____

2 Bladder Emptying

Do you have problems urinating or emptying your bladder completely? Yes No

How long? _____ months _____ years

Dribbling after you stand? Yes No Difficulty starting your stream? Yes No

Assume abnormal positions to urinate? Yes No Strain to empty? Yes No

Feel empty after passing urine? Yes No

Is your urine flow: Strong | Weak | Dribbling | Intermittent

3 Prolapse / Vaginal Support

Do you have fullness, pressure, or a bulge/protrusion of vaginal tissue? Yes No

How long have you had a bulge? _____ months _____ years

Do you notice a bulge? Yes No

Worse at day's end / after standing? Yes No

Push it back to empty bladder/bowel? Yes No

Ever used a pessary? Yes No

Surgery to repair prolapse? Yes No

4 Bowel Symptoms

Do you have problems with your bowels — incontinence or difficulty emptying? Yes No

How long? _____ months _____ years Episodes per week? _____

Accidental loss of solid stool? Yes No

Accidental loss of liquid stool? Yes No

Accidental loss of gas? Yes No

Wear protective pads? Yes No

Constipation? Yes No

Diarrhea? Yes No

Bloating? Yes No

Frequent desire to move bowels? Yes No

Feel bowels never completely empty? Yes No

Use fingers to help a bowel movement? Yes No

Seen a physician for bowel symptoms? Yes No

If yes, who? _____

5 Sexual History

Are you sexually active? Yes No

If not active, are barriers due to:

Prolapse Incontinence Pain

6 Pelvic Pain

Do you have pain in your pelvic area? Yes No

Where is your pain? *(check all that apply)* Pelvic area Vagina Rectum Lower abdomen

How long? _____ months _____ years

Relieved by emptying your bladder? Yes No

Pain with urination? Yes No

See a pain specialist? Yes No

If yes, who? _____

Does anything relieve the pain? Yes No

If yes, what? _____