Urogynecology New Patient Intake Form

Name _____________________________________________ Date of Birth ___________________ Age _________
Referring Provider ________________________________________________________________

What is the main reason for your visit?
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Have you received any treatments for this issue in the past?
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

What are your goals for the visit today?
1. _______________________________________________________________________________________________
   ___________________________________________________________________________________________________
   ___________________________________________________________________________________________________
2. _______________________________________________________________________________________________
   ___________________________________________________________________________________________________
   ___________________________________________________________________________________________________
3. _______________________________________________________________________________________________
   ___________________________________________________________________________________________________

Urinary Symptoms:
Do you experience urinary leakage? Yes/No
   If yes, how long? _________ months/years

Please check if you leak urine during the following times:
   ☐ coughing/sneezing/laughing
   ☐ walking/running/exercising
   ☐ with intercourse
   ☐ with urgency/on the way to the bathroom
   ☐ minimal activity
   ☐ lying down

Do you use a pad for leakage? Yes/No
   If yes, how many in a day? _________

What amount of leakage do you experience? ☐ Drops ☐ More than drops ☐ Flood

How long can you postpone emptying your bladder when you have the urge? ________min/hr

After emptying your bladder do you feel like you have completely finished? Yes/No

Do you find it hard to begin urinating? Yes/No

How many times do you urinate during the day? _______________

How many times do you urinate during the night after you go to sleep? ____________

Number of urinary tract infection in the last year? _____________

Any kidney infections (pyelonephritis)? Yes/No

Any history of kidney stones? Yes/No

Any blood in the urine? Yes/No

Did you have any urinary problems in childhood? Yes/No

Patient Label
placed here

Wake Specialty Physicians
Women’s Center
Urogynecology New Patient Intake Form
(This form is not a part of permanent record)

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**Bowel Symptoms:**
How often do you have a bowel movement? ____________________________
Do you strain to have a bowel movement? Yes/No
Do you push with a finger in the vagina to assist with a bowel movement? Yes/No
Do you have constipation? Yes/No
Do you use any laxatives? Yes/No
Do you have diarrhea/loose stools?
Do you have fecal urgency and do not make it to the bathroom in time? Yes/No
Do you have fecal seepage or staining on your underwear? Yes/No
Do you usually lose stool beyond your control if your stool is loose? Yes/No
Do you have difficulty controlling formed stool? Yes/No

**Prolapse Symptoms:**
Do you feel any vaginal or lower abdominal pressure? Yes/No
Do you see or feel a bulge or something falling out in the vaginal area? Yes/No
Do you see or feel a bulge or something falling out in the rectal area? Yes/No

**Sexual Symptoms:**
Have you ever had sexual relations? Yes/No
   If yes, do you have pain with sex? Yes/No
   If yes, are you satisfied with your sex life? Yes/No
Are you currently having sexual relations? Yes/No

Do you have any major medical problems (i.e. diabetes, high blood pressure)? ____________________________
_________________________________________________________________________________________________
Have you ever had problems with heart problems, blood clots, or anesthesia problems? Yes/No
Explain:__________________________________________________________________________________________
What surgeries have you had in the past? _______________________________________________________________
_________________________________________________________________________________________________
What medical problems run in your family? ______________________________________________________________
_________________________________________________________________________________________________
What medication do you take (include over the counter medications, herbal medications, and vitamins)?________
_________________________________________________________________________________________________
What allergies do you currently have (medications, latex, foods, environment)?____________________________
_________________________________________________________________________________________________
How many times have you ever been pregnant?__________________
Of these pregnancies, how many were: preterm (premature) deliveries ____________________________
full term deliveries ____________________________
miscarriages or abortions ____________________________
Of the deliveries, how many were: vaginal deliveries only? ____________________________
vaginal deliveries with forceps assistance? ____________________________
vaginal deliveries with vacuum assistance? ____________________________
cesarean deliveries? ____________________________
Of the vaginal deliveries, did you have any large tears (3rd or 4th degree)? Yes/No
What is the weight of your largest baby? ____________________________
When was the first day of your last period? __________________________________________
How often do you have your period? __________________________________________
How long does your period last? __________________________________________
Have you ever had an abnormal pap test? __________________________________________
Have you ever had a pelvic infection (i.e. gonorrhea, chlamydia, herpes)? __________________________________________
Do you have a sexual partner? Yes/No Is that partner male or female? __________________________________________
When was your last:
Pap test ____________________________ Colonoscopy ____________________________
Mammogram ____________________________ Bone Density test ____________________________
Cholesterol screen ____________________________ Tetanus shot ____________________________
Are you? Single/Married/Partnered/Divorced/Widowed
Who do you live with? __________________________________________
Are you currently? Working/Retired/Unemployed
What is your occupation? __________________________________________
Do you exercise regularly? Yes/No
Describe your current exercise routine: __________________________________________
We recommend limiting tobacco use. Do you currently smoke? Yes/No
If yes, how many cigarettes or packs per day? __________________________________________
If yes, would you like help quitting smoking? Yes/No
Have you ever smoked in the past? Yes/No
If yes, when did you quit? __________________________________________
How much alcohol do you use: ____________________________ day/week/month
What street drugs do you use? ____________________________ How often? ____________________________
Domestic violence (including emotional physical and sexual abuse) is a serious health threat to women. Has anyone hurt you in the past? __________________________________________
Is anyone hurting you now in any way? __________________________________________
# Update of Personal Medical History and Review of Symptoms

If you have a problem now, or if you have had a problem with any of the following body systems in the past, please check and explain at the bottom. Thank you.

## Cardiovascular
- Blood pressure
- Heart
  - Heart attack
  - Chest pain-angina
  - Murmur-valve problem
  - Failure
- Blood vessels

## Respiratory
- Lungs (Breathing problems, Asthma, TB)
- Cough
- Wheezing
- Shortness of breath

## Gastroenterological
- Abdomen (constipation, ulcers)
- Rectum
- Liver (hepatitis)

## Endocrine
- Diabetes
- Thyroid

## Eyes, Ear, Nose, Throat
- Eyes
- Ears
- Nose and Sinuses
- Mouth
- Throat

## Genitourinary
- Breast
- Uterus
- Ovaries
- Kidney
- Pelvis Infection
- Vagina
- Tubes
- Cervix
- Incontinence

## Musculoskeletal
- Joints (arthritis)
- Muscles
- Bones

## Dermatologic
- Skin/rashes, moles, ulcers
- Lymph nodes

## Neurological
- Loss of sensation
- Loss of strength
- Memory loss
- Dizziness / fainting
- Migraines
- Seizures

## Hematologic
- Anemia
- Blood clots
- Easy Bleeding
- HIV
- Blood transfusion

## Psychiatric
- Schizophrenia
- Depression
- Anxiety
- Insomnia

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Notes: 

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**Wake Specialty Physicians**

**Women's Center**

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