McLAREN MEDICAL GROUP

UROGYNECOLOGY

UROGYNECOLOGY HISTORY

Name: _____ Appointment Date: _____

Age: _____ Date of Birth: _____ Date Completed: _____

Reason for Visit: _____

_____

PLEASE PROVIDE NAME, ADDRESS, PHONE AND FAX NUMBERS FOR THE FOLLOWING PHYSICIANS OR HEALTHCARE PROVIDERS:

Primary Care Physician: _____ Phone: _____ Fax: _____

Address: _____
CITY STATE ZIP

Regular Gynecologist: _____ Phone: _____ Fax: _____

Address: _____
CITY STATE ZIP

URINARY INCONTINENCE	
Do you have any accidental loss of urine?	❑ Yes ❑ No
How many months or years have you had leakage of urine?	_____
Do you wear pads to absorb lost urine?	❑ Yes ❑ No
If yes, what size pad do you wear?	YRS MOS
How many pads do you wear in a day?	_____
How many trips to the bathroom do you make during the day from the time you wake up until you go to sleep at night?	_____
Does an uncomfortably strong need to pass urine wake you up?	❑ Yes ❑ No
How many times are you awakened during the night by an urge to urinate?	_____
Does the sound, sight or feel of running water cause you to lose urine?	❑ Yes ❑ No
Do you lose urine during the act of intercourse at penetration?	❑ Yes ❑ No
Do you lose urine during orgasm?	❑ Yes ❑ No
Do you lose urine during coughing, sneezing, running, or lifting?	❑ Yes ❑ No
Do you lose urine with changes in posture, standing or walking?	❑ Yes ❑ No
Do you lose urine continuously such that you are constantly wet?	❑ Yes ❑ No
Have you seen a physician for complaints of urine loss?	❑ Yes ❑ No
Have you taken medicine to prevent urine loss?	❑ Yes ❑ No
If yes, name of medication? _____	
Have you had surgery to prevent urine loss?	❑ Yes ❑ No
If yes, was it done through the vagina?	❑ Yes ❑ No
Was it done through the abdomen?	❑ Yes ❑ No
Do you notice any dribbling starting your urine stream?	❑ Yes ❑ No
Have you ever required catheterization for the inability to pass urine?	❑ Yes ❑ No
Do you have any burning with urination?	❑ Yes ❑ No
Have you had three or more urinary tract infections in the last year?	❑ Yes ❑ No

GENITOURINARY PROLAPSE	
Do you have a bulge or mass in your vagina?	❑ Yes ❑ No
How many months or years have you had this bulge or mass?	_____
Have you seen a doctor for this bulge or mass in your vagina?	❑ Yes ❑ No
Have you worn a pessary for this problem?	❑ Yes ❑ No
If yes, how many months or years have you worn this pessary?	YRS MOS
Have you had surgery in the past for a bulge or mass in the vagina?	❑ Yes ❑ No

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UROGYNECOLOGY

UROGYNECOLOGY HISTORY

PAST OBSTETRICAL HISTORY			
Number of pregnancies:	_____	Number of C-sections:	_____
Number of vaginal births:	_____	Weight of largest baby:	_____

SEXUAL HISTORY					
Are you sexually active?	❑ Yes	❑ No	Do you use contraception?	❑ Yes	❑ No
If no, please select from the following:			If yes, please select from the following:		
No partner?	❑ Yes	❑ No	Tubal ligation?	❑ Yes	❑ No
Partner factor?	❑ Yes	❑ No	Birth control pills?	❑ Yes	❑ No
Loss of sex drive?	❑ Yes	❑ No	Intrauterine device (IUD)?	❑ Yes	❑ No
Painful intercourse?	❑ Yes	❑ No	Diaphragm?	❑ Yes	❑ No
Because of bulge or leak symptoms?	❑ Yes	❑ No	Depo-Provera?	❑ Yes	❑ No
Other:_____			Barrier?	❑ Yes	❑ No
Partner: ❑ Male ❑ Female ❑ Both			Postmenopausal?	❑ Yes	❑ No
			Other:_____		
Do you have pain with intercourse?	❑ Yes	❑ No			
If yes: ❑ Near vaginal opening? ❑ Inside abdomen/pelvic area? ❑ Both?					

PAST GYN HISTORY		
Last pap test:	LMP_____	
Have you ever had an abnormal pap smear?	❑ Yes	❑ No
If yes, what year?	_____	
Last mammogram:	_____	
Have you ever had an abnormal mammogram?	❑ Yes	❑ No
If yes, what year?	_____	
Have you ever gone through menopause?	❑ Yes	❑ No
If yes, at what age?	_____	
Are your periods regular?	❑ Yes	❑ No
How many days do you bleed?	_____	
Have you had any vaginal bleeding or spotting since menopause?	❑ Yes	❑ No
Have you had a hysterectomy?	❑ Yes	❑ No
If yes, was it done through: ❑ the vagina? ❑ the abdomen? ❑ Laparoscopically?		
Do you have your ovaries? If yes: ❑ Both? ❑ Only one?		
Have you had surgery for leakage of urine?	❑ Yes	❑ No
Have you had surgery for prolapse, "bulges," or "fallen pelvic organs?"	❑ Yes	❑ No

Patient Name:

Date of Birth:

Appointment Date: