CAPE REGIONAL PHYSICIANS ASSOCIATES

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Name: _____ Date of Birth: _____

Pelvic Pain and Urgency/Frequency Patient Symptom Scale

For the questions below, please circle the answer that best describes how you feel. The last column is for your doctor to assess your score. Please do not mark in this column. Be sure you bring this questionnaire with you to the examination room so that you can review your answers with the doctor.

		0	1	2	3	4	Score
1	How many times do you urinate during waking hours?	3-6	7-10	11-14	15-19	20+	
2	How many times do you get out of bed to urinate?	0	1	2	3	4+	
3	If you get up at night to urinate, to what extent does it usually bother you?	None	Mild	Moderate	Severe		
4	Do you have pain associated with your bladder or in the pelvis (vagina, lower abdomen, urethra, and perineum)?	Never	Occasionally	Usually	Always		
5	Do you still have urgency shortly after urinating?	Never	Occasionally	Usually	Always		
6	If you have pain is it usually:		Mild	Moderate	Severe		
7	How often does pain bother you	Never	Occasionally	Usually	Always		
8	If you have urgency, is it usually:		Mild	Moderate	Severe		
9	How often does your urgency bother you?	Never	Occasionally	Usually	Always		
10	Are you sexually active?	Yes or No					
11	If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always		
12	If you have pain, does it make you avoid intercourse?	Never	Occasionally	Usually	Always		

Name: _____ Date of Birth: _____

Urogynecology New Patient Information

Date: _____

Primary Care Physician: _____

Reason for Today's Visit: _____

Medical History: Please circle any health condition that applies to you and specify/comment if needed. If you have any questions, please ask a member of our staff for assistance. Thank you.

Medical History (For "Other," Please Specify)	**Specify/Comments**
Alcohol/Drug Problem	
Breast Lump, Other breast problem	
Cardiac Congestive Heart Failure, Heart attack, Heart Disease, High blood pressure, High cholesterol, Valve problem, Other	
Cancer Brain, Breast, Cervical, Colon, Lung, Ovarian, Prostate, Rectal, Skin, Thyroid, Uterine, Other	
Digestive/Stomach Barrett's Esophagus, GERD, Hernia, Intestinal problem, Liver Disease, Ulcer, Other	
Endocrine Diabetes, Thyroid Disease, Other	
Eyes/Ears/Nose/Throat	
Hematology Anemia, Bleeding disorder, Clotting disorder, Other	
Immune Disorder AIDS, HIV, Lupus, Other	
Kidney Disease, Kidney stone, Other kidney problem	
Musculoskeletal Arthritis/Joint problem, Hernia, Osteoporosis/Osteopenia, Other	
Neurological Nerve Disease, Stroke, Other	
Psychiatric Anxiety, Depression, Other	
Respiratory Asthma, COPD, Other	
Skin Eczema, Psoriasis, Other	
Urinary / Reproductive Abnormal pap test, Bladder problem, Menstrual abnormality, Prostate problem, Sexually transmitted infection, Other	
Vascular (Arteries, veins)	
Other Medical History:	

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CRPA Urogynecology

Name: _____ Date of Birth: _____

Medication: Please list all medications with dose and frequency.
(Please include non-prescription medications, vitamins, and supplements)

Medication	**Dose**	**Frequency** (i.e., how many times daily?)	**Prescribed By**

Pharmacy: Where would you like us to send your prescriptions?
Local pharmacy name, location: _____
Mail order pharmacy name: _____

Do you take any of the following blood thinners? (Circle any that apply):
Aspirin, Ibuprofen-based products (Ex. Motrin, Advil), Coumadin, Lovenox, Plavix, Xarelto, Pradaxa

Do you need any medication refills today? If so please list:

_____

Allergies: Please list ALL medication, food, and/or environmental allergies, and specify reaction type that occurs (i.e. rash, itching).

Have you ever had an anaphylactic reaction (severe, near deadly reaction)?: (Circle) Yes / No

Family History: Please note any serious family medical history

Father:	Father's Father:
Mother:	Father's Mother:
Brother:	Mother's Father:
Sister:	Mother's Mother:
Other Family History:	

Social History: (Please circle the following that apply to you):
Are you: Single Married Divorced Other
Are you sexually active? Yes No
What is your employment/occupation? _____
Please outline your use of the following products, past or present:

Product	**Current Use? Yes/No**	**Daily Amount**	**Weekly Amount**	**Past Use? Yes/No**
Tobacco				
What did you use to smoke? ____ cigarettes, ____ pipe, ____ cigars, ____ chewing tobacco				
Alcohol				
Recreational Drugs				
Caffeine				

Do you use other forms of nicotine products? (circle) smokeless tobacco, electronic cigarettes? _____

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CRPA Urogynecology

Name: _____ Date of Birth: _____

Immunization:

Immunization up to date?	Yes/No	When?
Flu Vaccine this year?	Yes/No	
Pneumonia	Yes/No	
Tetanus	Yes/No	
Pertussis	Yes/No	
Zostavax	Yes/No	
History of Blood Transfusion?	Yes/No	

Do you have a Living Will/Advance Directive? _____

Health Maintenance: Please note the most recent date you received any of the below health services.

Service	**Date (Month/Year)**	**Physician**
Yearly Physical		
Eye Exam (If **Dilated** Eye Exam, please specify)		
Dental Exam		
Pap Smear		
Prostate Exam		
Mammogram		
Colonoscopy		
Diabetic Foot Exam		

Recent Diagnostic Studies: (within the last 3 years)

1. Heart Testing (Type / Where / When) _____
2. Lung Testing (Type / Where / When) _____
3. X-Ray (Where / When / Specify Body Part) _____
4. Ultrasound (Where / When / Specify Body Part) _____
5. CT (Where / When / Specify Body Part) _____
6. MRI (Where / When / Specify Body Part) _____
7. Biopsy (Where / When / Specify Body Part) _____
8. Other (Type / Where / When) _____
9. Most Recent Blood Testing/Labs (Where / When) _____

Past Surgical History/Past Procedures:

_____

_____

Recent Hospitalization(s):

_____

_____

_____

Current and/or Previous Medical Specialists: (Name/Specialty)

_____

_____

_____

Signature of patient or guardian Printed name of patient or guardian Date

Name: _____ Date of Birth: _____

New Patient Assessment

Do you still have your uterus? Yes or No

Do you have fecal incontinence? Yes or No

Voiding Symptoms:

- ☐ Frequency
- ☐ Loss of urine when unaware
- ☐ Urgency
- ☐ Loss with urge
- ☐ Dysuria (painful urination)
- ☐ Sensation of incomplete emptying
- ☐ Enuresis (involuntary urination)
- ☐ Loss with sex
- ☐ Nocturia (urinary frequency at night)
- ☐ Loss with stress
- ☐ Wears Protection
- ☐ Strain to empty
- ☐ Cough/Leak with position_____
- ☐ Dribbling
- ☐ Wait to void
- ☐ Unusual position to void

Consistency of urine stream:

- ☐ Intermittent
- ☐ Continuous

Flow of urine stream:

- ☐ Strong
- ☐ Weak
- ☐ Variable

Prolapse symptoms:

- ☐ Falling out
- ☐ Prolapsed / Protrusion
- ☐ Bulging
- ☐ Heaviness
- ☐ Pain
- ☐ Other: ___