Urology Associates of Danbury, P.C.

Urogynecology

Patient Name: ________________________________ Date: __________________________

Referring Doctor______________________________ Date of Birth: ____________________

Primary Care Physician: ________________________ Gynecologist: ____________________

Chief Complaint: What is the main reason for your visit today?_______________________________________

What are the reasons for your visit? (Check all that apply)

☐ Urinary leakage with cough/sneeze/exercise
☐ Vaginal bulging or protrusion
☐ Frequent urination
☐ Inability to postpone urination
☐ Pelvic pain
☐ Bladder pain
☐ Bladder Infections
☐ Loss of bowel control
☐ Interstitial cystitis
☐ Other: ________________________________

How long has this problem bothered you? ____

What are your expectations in seeking help for this problem?

☐ Complete cure ☐ Reduce severity of symptoms ☐ Want diagnosis ☐ Second opinion

Other (please explain) ____

Gynecologic History: Are you post- menopausal (circle): N or Y

☐ **No** (answer questions in box below)	☐ **Yes** (answer questions in box below)
Date of last normal menstrual period: ____/_____/_____ Describe your current periods: ☐ Regular ☐ Irregular ☐ Painful ☐ Heavy How long does your period last? _______ days How often do you get it? Every ______ days What do you use to prevent pregnancy? ☐ N/A ☐ Pill/Patch/Ring ☐ Depo- Provera ☐ IUD ☐ Barrier method ☐ Tubal ligation ☐ Vasectomy	How old were you when you experienced you last menstrual period? ________ years old Have you experienced any post-menopausal bleeding? ☐ No ☐ Yes Are you taking any hormone therapy (estrogen or progesterone)? ☐ No ☐ Yes If yes please indicate type: Oral/patch? ☐ No ☐ Yes Vaginal / topical? ☐ No ☐ Yes

Do you experience pain with intercourse (circle): Y or N

Do you have a history of sexually transmitted infections (circle): Y or N

Have you ever had an abnormal Pap smear (circle): Y or N

Date of last Pap smear ______________ Was it (circle): Normal or Abnormal

Obstetric History:

No. of pregnancies:_______ No. of vaginal deliveries:________ No. of C. Sections:__________

Were Forceps or a Vacuum used during delivery:

Largest Baby: ______lbs ____oz

ALLERGIES:			
Medications	**Dosage**	**How Often**	**Notes**

List Medical Problems: (Please list any chronic illnesses, past surgeries or hospitalizations)

☐ High Blood Pressure ☐ Heart Problems ☐ Heart Murmur ☐ Afibrillation
☐ Diabetes ☐ Asthma ☐ Valve Replacement ☐ Coronary Disease
☐ Heart Problems ☐ Glaucoma ☐ Joint Replacement

Other (Please list):____

____

List Hospitalizations:____

____

GYN History:

☐ Abnormal vaginal bleeding ☐ History of ovarian cysts ☐ History of fibroids ☐ History of abnormal Pap
☐ History of STD's

Surgical History:

Have you had a hysterectomy (circle): Y or N

If yes: Abdominal or Vaginal ___________.

Were you ovaries removed (circle): Y or N

Have you had any prior procedures on the urinary tract?

☐ Ureteral dilation ________ ☐ Cystoscopy________ ☐ Urodynamics (bladder testing)______

☐ Collagen Injections ________ ☐ Bladder distension ______

Other Surgeries ____

____

Social History:

Do/did you smoke: Yes No How much______________ No. of years______ When did you stop______

Number of Alcoholic Beverages per week___________________________________

Do you use any illegal drugs____

Occupation:____

Family History: ☐ Unknown Family History

	Relation		Relation
Bladder Cancer	______________________________	Kidney Stone	______________________________
Prostate Cancer	______________________________	Kidney Disease NOS	______________________________
Kidney Cancer	______________________________	Diabetes	______________________________
Uterine Cancer	______________________________	Heart Disease	______________________________
Ovarian Cancer	______________________________		
Breast Cancer	______________________________		

Screening:

Date of Last Mammogram _____/_____/_____ (circle): Normal Abnormal Never Had One

Date of Last Colonoscopy _____/_____/_____ (circle): Normal Abnormal Never Had One

Are any members of your immediate family deceased? ☐ Mother ☐ Father ☐ Sister ☐ Brother