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 ☐ Bladder pain

☐ Vaginal bulging or protrusion ☐ Bladder Infections

☐ Frequent urination ☐ Loss of bowel control

☐ Inability to postpone urination ☐ Interstitial cystitis

☐ Pelvic pain ☐ 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

Surgical History:

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

If yes: Abdominal or Vaginal _____.

Were your 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 _____

_____

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