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Appointment **Date**  
**Check-In**

**PATIENT HISTORY FORM**

*Note: This is a confidential record that will be shredded upon entry into our electronic health record. Information contained here will not be released to anyone without your authorization to do so.*

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_ Age: \_\_\_\_\_

Who referred you to us? \_\_\_\_\_ Who is your primary care provider? \_\_\_\_\_

To whom would you like us to fax your consultation note? \_\_\_\_\_

**How did you hear about OMC Pelvic Health (circle one)?** My Primary Care Internet  
Friends/family ER/urgent care Web Site Other

**Chief Complaint:** What is the main symptom would you like for us to address today?

\_\_\_\_\_

**Have you seen an urologist, gynecologist, urogynecologist or FPMRS specialist before (circle one)?** Y N

If yes, please provide information below:

Name of facility: \_\_\_\_\_ Approximate date of service: \_\_\_\_\_

**Have you had an ultrasound, X-ray, MRI, or CT (CAT) scan of your abdomen or pelvis? (circle one)?** Y N

If yes, please list what type (i.e., CT, MRI), and where done (Swedish, Virginia Mason, Overlake etc.):

\_\_\_\_\_

**Please list all of your current and past medical diagnoses:**

1) \_\_\_\_\_ 5) \_\_\_\_\_

2) \_\_\_\_\_ 6) \_\_\_\_\_

3) \_\_\_\_\_ 7) \_\_\_\_\_

4) \_\_\_\_\_ 8) \_\_\_\_\_

**SURGICAL HISTORY:** Please list your past Surgeries.

***Type of Surgery***

***Date of Surgery***

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

**FAMILY HISTORY:** Does anyone in your immediate family (parents, siblings, children) have a history of heart disease, heart attack, diabetes, ovarian cancer, breast cancer, kidney cancer, bladder cancer, colon cancer, or any other serious illnesses?

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

**SOCIAL HISTORY:**

**Tobacco History (circle one)?** Never Smoked      Current Smoker    Age Started: \_\_\_\_\_

Former Smoker (Age started: \_\_\_\_\_ Quit Date: \_\_\_\_\_)

Years smoked: \_\_\_\_\_ Number of cigarettes per day (circle one): < ½ pack    ½ pack    1 pack    > 1 pack

**Relationship status (circle one):**    Single                      Married                      Divorced                      Significant other

**How much do you drink per day of the following (best estimate):**

Coffee/ Tea/ Caffeine \_\_\_\_\_

Carbonation (soda, sparkling water) \_\_\_\_\_

Water: \_\_\_\_\_

Alcohol: \_\_\_\_\_

**OBSTETRICAL HISTORY:**

**Number of Pregnancies:** \_\_\_\_\_ **# of Vaginal Deliveries:** \_\_\_\_\_ **# of Cesarean Deliveries:** \_\_\_\_\_

Date of Delivery (Year)	Type of Delivery (Vaginal, C/S, Forceps, etc)	Birthweight (lb/oz or Kg)	Gender (M/ F)	Complications (Perineal tear, hemorrhage, pre-eclampsia)

**GYNECOLOGIC HISTORY**

**Date of Last PAP Smear:** \_\_\_\_\_ **History of abnormal PAP Smears?:** \_\_\_\_\_

**Date of Last Mammogram:** \_\_\_\_\_ **History of abnormal mammogram?:** \_\_\_\_\_

**Date of Last Colonoscopy:** \_\_\_\_\_ **History of abnormal colonoscopy?:** \_\_\_\_\_

**Date of Last Menstrual Cycle:** \_\_\_\_\_ **History of hormone use currently or in the past? Y N**

**Date of Last Bone Density:** \_\_\_\_\_

**Current Form of Birth Control (circle all that apply):** Menopause    Abstinence    Condoms    Pills    IUD

Vasectomy    Tubal Ligation    Other: \_\_\_\_\_

**Please write any further comments or things you would like us to know in the space below:**

**Medication list—for your safety, please list all medications that you take along with doses.**

Include supplements, topical creams such as steroids or vaginal estrogen, over the counter and prescription medications. If you have some medications that you only take “as needed” please include those too. Because medications we may prescribe can have unsafe interactions with other medications, please provide an accurate list along with dosages below.

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_
- 7) \_\_\_\_\_
- 8) \_\_\_\_\_
- 9) \_\_\_\_\_
- 10) \_\_\_\_\_

**ALLERGIES:**

***Medication***

***Reaction (hives, rash, can't breathe, etc)***

- |          |          |
|----------|----------|
| 1) _____ | 1) _____ |
| 2) _____ | 2) _____ |
| 3) _____ | 3) _____ |
| 4) _____ | 4) _____ |

**If we order medications after your visit today what pharmacy would you like to use?**

**Name of pharmacy:**

**Location:**

\_\_\_\_\_

\_\_\_\_\_

### Pelvic Floor Distress Inventory Questionnaire – Short Form 20

Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and if you do how much they bother you. Answer each question by putting an X in the appropriate box or boxes. If you are unsure about how to answer, please give the best answer you can. While answering these questions, please consider your symptoms over the **last three months**.

If **yes**, how much does it bother you?

		Not at all	Somewhat	Moderately	Quite a bit
Do you usually experience pressure in the lower abdomen?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually experience heaviness or dullness in the lower abdomen?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually experience a feeling of incomplete bladder emptying?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever have to push up in the vaginal area with your fingers to start or complete urination?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel you need to strain too hard to have a bowel movement?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel you have not completely emptied your bowels at the end of a bowel movement?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually lose stool beyond your control if your stool is well formed?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually lose stool beyond your control if your stool is loose or liquid?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually lose gas from your rectum beyond your control?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually have pain when you pass your stool?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does part of your stool ever pass through the rectum and bulge outside during or after a bowel movement?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually experience frequent urination?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually experience urine leakage related to laughing, coughing, or sneezing?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually experience small amounts of urine leakage (that is, drops)?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually experience difficulty emptying your bladder?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you usually experience pain or discomfort in the lower abdomen or genital region?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Urogenital Distress Inventory. For each question, circle the best response.

<b>Do you experience, and if so, how much are you bothered by...</b>	<b>Not at all</b>	<b>Slightly</b>	<b>Moderately</b>	<b>Greatly</b>
Frequent urination	0	1	2	3
Leakage related to feeling of urgency	0	1	2	3
Leakage related to physical activity, coughing, or sneezing	0	1	2	3
Small amounts of leakage (drops)	0	1	2	3
Difficulty emptying bladder	0	1	2	3
Pain or discomfort in lower abdominal or genital area	0	1	2	3