Women's Urology and Pelvic Health Center | Patient History Questionnaire

Today's Date: _____

Name:	Age:
Preferred name:	
Date of birth:	Primary phone: ☐ Home ☐Cell ☐ Work
Email:	Secondary phone: ☐ Home ☐Cell ☐ Work
	OK to leave detailed message? ☐ Yes ☐ No
Would you like to receive text message appointment reminders? ☐ Yes ☐ No If yes: ☐ Primary phone ☐ Secondary phone ☐ _____	
Primary hospital: ☐ Beaumont ☐ Other _____	
Emergency contact (name, phone number, relationship):	

What is the main reason for your visit today?

Marital Status:	☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced
Who do you live with?	
Education:	☐ Less than 12 years ☐ College Degree ☐ Some college ☐ High school graduate ☐ Postgraduate degree
Occupation:	☐ Retired

Caffeine use:	☐ None ☐ 1 serving ☐ 2-3 servings ☐4-6 servings ☐ 6+ servings
Alcohol use:	☐ Yes _____ per week ☐ No
Tobacco use:	☐ Never used ☐ Current smoker _____ per day for _____ years ☐ Former smoker _____ per day for _____ years Quit date: _____
Street drug use:	☐ Yes _____ ☐ No ☐ Prefer not to answer
Regular exercise:	☐ None ☐ Moderate Activity (3-5 times a week) ☐ Light Activity (1-3 times a week) ☐ Very active (intense exercise 6-7 times a week)

Past Medical History					
Back Injury	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No	Fibromyalgia	☐ Yes ☐ No
Shingles	☐ Yes ☐ No	Heart problems	☐ Yes ☐ No	Migraines	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Thyroid disease	☐ Yes ☐ No	Eating disorder	☐ Yes ☐ No
Seizures	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Other psychological	☐ Yes ☐ No
Endometriosis	☐ Yes ☐ No	Type:		Type:	
Other:					

Surgical History			
Surgery	Date	Surgery	Date

Medications			
Allergies: ☐ None ☐ Allergic to: _____			
Medication Name (include prescription, over the counter, supplements, and topicals)	Strength or dose	Frequency	Month/year started

Family Medical History	☐ Check here if family medical history is unknown		
☐ Bladder/kidney cancer Who: _____	☐ Uterine/ovarian cancer Who: _____	☐ Colorectal cancer Who: _____	☐ Breast cancer Who: _____
☐ Chronic pelvic pain Who: _____	☐ Bladder prolapse Who: _____	☐ Interstitial cystitis Who: _____	☐ Other bladder problems Who: _____
☐ Autoimmune disease Who: _____	☐ Crohn's/ulcerative colitis Who: _____	☐ Colon polyps Who: _____	☐ Multiple sclerosis Who: _____
☐ Fibromyalgia Who: _____	☐ Kidney stones Who: _____	☐ Other: _____	

Urologic History	
Have you seen a urologist before? ☐ Yes ☐ No If yes, for what problem? _____ Name: _____	
How often do you urinate **during the day**:	How often do you urinate **at night**:
On average, how much do you drink each day? Water: Soda/pop: Coffee/tea: Alcohol: Juice: Other:	
Do you have a strong urge to empty your bladder?	☐ Yes ☐ No
If so, are you able to get to the bathroom in time?	☐ Yes ☐ No
Do you leak with coughing, sneezing, or laughing?	☐ Yes ☐ No
Do you wear pads due to urine leakage?	☐ Yes ☐ No If yes: ☐ thick pad ☐ thin pad
Do you have frequent bladder infections? (3 or more a year)	☐ Yes ☐ No
Have you had kidney stones?	☐ Yes ☐ No
Do you experience bedwetting?	☐ Yes ☐ No
Have you ever been diagnosed with *interstitial cystitis*?	☐ Yes ☐ No ☐ Not sure
If yes: Year: _____ By whom: _____	
Did you have a *cystoscopy with hydrodistention*?	☐ Yes ☐ No ☐ Not sure
Have you been told you have *Hunner's ulcers*?	☐ Yes ☐ No ☐ Not sure

Gynecologic History				
Birth Control Method:	☐ Not sexually active	☐ Menopause	☐ Hysterectomy	☐ Female partner
	☐ Tubal ligation	☐ Vasectomy	☐ Condoms	☐ Pill/patch/ring
	☐ Depo shot	☐ Mirena IUD	☐ Paragard IUD	☐ Implant (i.e. Nexplanon)
	☐ Withdrawal	☐ Spermicide	☐ Diaphragm	☐ None
Current gynecologist:				
Last Pap smear:	_____	History of abnormal pap smear?	☐ Yes	☐ No
Sexually transmitted infection history:	☐ Herpes	☐ HPV/warts	☐ Chlamydia	☐ HIV
	☐ Gonorrhea	☐ Syphilis	☐ Trichomonas	

Menstrual History (skip this section if you do not currently have menstrual periods)			
First day of **last** menstrual period:		Age of **first** period:	
How many days does your period last?		How often does your period occur?	
Pain with periods?	☐ No	☐ Before	☐ During
Bleeding is: ☐ Heavy	☐ Moderate	☐ Light	Bleeding between periods? ☐ Yes ☐ No

Obstetric History			
Number of pregnancies:			Number of births:
Year	Birth weight	Vaginal or C-section?	Complications (including stitches, tears, infection, vacuum/ forceps, unusual bleeding, gestational diabetes, preeclampsia, etc)

Menopause History (skip this section if not menopausal)	
Menopause age: _____	Concerns about menopausal symptoms today? ☐ No ☐ Yes If yes, please explain:
How did you go through menopause:	☐ Naturally ☐ Medication induced ☐ Surgically—check all that apply ☐ uterus only removed ☐ uterus and one ovary removed ☐ uterus and both ovaries removed ☐ unsure ☐ abdominal ☐ laparoscopic ☐ vaginal
Hormone replacement therapy?	☐ Current ☐ Past (years: _____) ☐ Never Type: _____

Sexual Health History		
Are you sexually active? ☐ Yes ☐ No	Age of first sexual activity:	
Sexually active with (check all that apply):	☐ Men ☐ Women	☐_____
Are you satisfied with your sexual activity status?	☐ Yes ☐ No	
Do you have pain with sexual activity?	☐ Yes ☐ No	
Would you like to discuss your sexual health at your visit?	☐ Yes ☐ No	
Any recent difficulty with orgasm or decreased libido?	☐ Yes ☐ No	☐ n/a

Bowel History	
Do you frequently have constipation?	☐ Yes ☐ No
Do you leak stool or bowel contents?	☐ Yes ☐ No
Have you been diagnosed with irritable bowel syndrome?	☐ Yes ☐ No
Do you experience frequent diarrhea?	☐ Yes ☐ No
Do you experience any rectal bleeding?	☐ Yes ☐ No
When was your last colonoscopy?	Year: _____ ☐ n/a

Psychological History	
Do you currently see a psychologist, counselor, or psychiatrist?	☐ Yes ☐ No
History of psychiatric hospitalization(s)? If yes, please note year(s):	☐ Yes ☐ No

Abuse History/Intimate Partner Violence Screening			
Have you ever been abused?	☐ Yes ☐ No		
If yes, please answer the following questions. If no, please proceed to the next section.			
Would you like a referral for assistance or counseling?	☐ Yes ☐ No		
What was the nature of abuse? (check all that apply)		☐ Intimate partner	Age(s):
☐ Physical	Age(s):	☐ Sexual	Age(s):
☐ Verbal	Age(s):	☐ Emotional	Age(s):

Pain History (skip this section if you do not have pain)	
Describe your pain:	
How long have you had this pain?	
What triggered this pain?	
How do you currently manage your pain?	
Pelvic Pain (skip this section if you do not have pelvic pain) 0 = no pain 10 = severe pain	
What is your level of pain with intercourse?	0 1 2 3 4 5 6 7 8 9 10
What is your level of burning-type vaginal pain **during** intercourse?	0 1 2 3 4 5 6 7 8 9 10
What is your level of burning-type vaginal pain **after** intercourse?	0 1 2 3 4 5 6 7 8 9 10
What is your level of deep pain during intercourse?	0 1 2 3 4 5 6 7 8 9 10
What would be an acceptable level of pain for you?	0 1 2 3 4 5 6 7 8 9 10

Three most significant stressors in your life right now:
1.
2.
3.

Treatment Goals: List your primary treatment goal(s) that you hope to accomplish today:

Name:	DOB:

OAB-Q (Bother)						
During the past 4 weeks, how bothered were you by…	Not at all	A little bit	Some-what	Quite a bit	A great deal	A very great deal
1. An uncomfortable urge to urinate?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
2. A sudden urge to urinate with little or no warning?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
3. Accidental loss of small amounts of urine?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
4. Nighttime urination?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
5. Waking up at night because you had to urinate?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
6. Urine loss associated with a strong desire to urinate?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

OAB-Q (Health Related Quality of Life)						
During the past 4 weeks, how often have your bladder symptoms…	Not at all	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
1. Caused you to plan “escape routes” to restrooms in public places?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
2. Made you feel like there is something wrong with you?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
3. Interfered with your ability to get a good night’s rest?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
4. Made you frustrated or annoyed about the amount of time you spend in the restroom?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
5. Made you avoid activities away from restrooms (i.e. walks, running, hiking)?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
6. Awakened you during sleep?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
7. Caused you to decrease your physical activities (exercising, sports, etc.)?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
8. Caused you to have problems with your partner or spouse?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
9. Made you uncomfortable while traveling with others because of needing to stop for a restroom?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
10. Affected your relationships with family and friends?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
11. Interfered with getting the amount of sleep you needed?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
12. Caused you embarrassment?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
13. Caused you to locate the closest restroom as soon as you arrive at a place you have never been?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

Pelvic Floor Distress Inventory Patient initials: _____

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 3 months.

		If yes, how much does it bother you?			
		Not at all	Some-what	Mode-rately	Quite a bit
1. Do you usually experience pressure in the lower abdomen?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
2. Do you usually experience heaviness or dullness in the lower abdomen?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
4. Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
5. Do you usually experience a feeling of incomplete bladder emptying?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
6. Do you ever have to push up in the vaginal area with your fingers to start or complete urination?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
7. Do you feel you need to strain too hard to have a bowel movement?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
8. Do you feel you have not completely emptied your bowels at the end of a bowel movement?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
9. Do you usually lose stool beyond your control if your stool is well formed?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
10. Do you usually lose stool beyond your control if your stool is loose or liquid?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
11. Do you usually lose gas from the rectum beyond your control?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
12. Do you usually have pain when you pass your stool?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
14. Does part of your stool ever pass through the rectum and bulge outside during or after a bowel movement?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
15. Do you usually experience frequent urination?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
16. 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 ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
17. Do you usually experience urine leakage related to laughing, coughing, or sneezing?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
18. Do you usually experience small amounts of urine leakage (that is, drops)?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
19. Do you usually experience difficulty emptying your bladder?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4
20. Do you usually experience pain or discomfort in the lower abdomen or genital region?	Yes ☐ No ☐	☐ 1	☐ 2	☐ 3	☐ 4

Patient initials: _____

GAD-7 (Anxiety Screening Tool)				
Over the past 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
3. Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it is hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable	☐ 0	☐ 1	☐ 2	☐ 3
7. Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3

PHQ-8 (Depression Screening Tool)				
Over the past 2 weeks, how often have you been bothered by any of the following:	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, or hopeless?	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep, or sleeping too much?	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy?	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating?	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down?	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television?	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?	☐ 0	☐ 1	☐ 2	☐ 3

If the reason for your visit is **not related to pain**,
you **do not** need to complete pages 8-11 of the questionnaires.

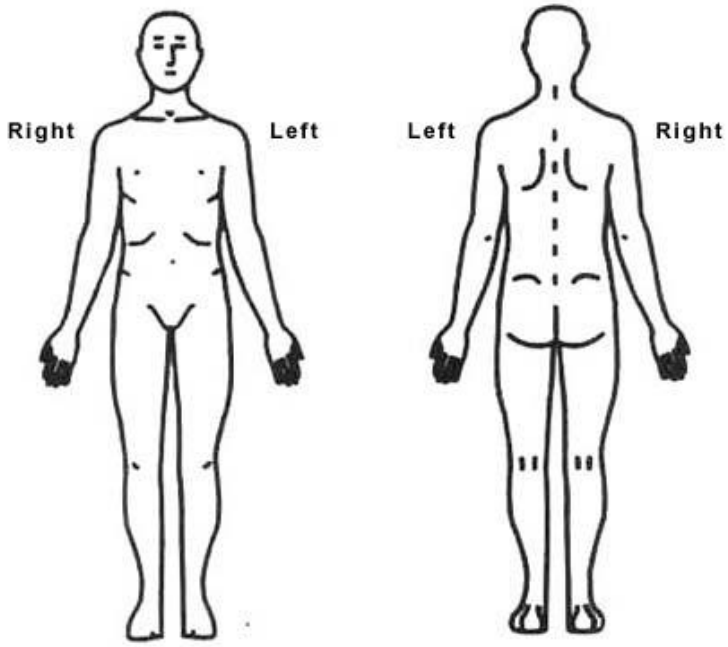
If you are experiencing pain, please complete the next 4 pages. Thank you.

Women's Urology and Pelvic Health Center | Brief Pain Inventory (BPI)

Patient initials: _____

1. Throughout our lives, most of us have pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these every-days kinds of pain today?
   ☐ Yes ☐ No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its worst in the last 24 hours

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its least in the last 24 hours

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on average

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have right now

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Pain as bad as you can imagine

7. What treatments or medications are you receiving for your pain? _____
   _____
   _____
   _____

8. In the last 24 hours, how much relief have pain treatment or medication provided? Please circle the one percentage that most shows how much relief you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No relief										Complete relief

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your

   a. General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

   b. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

   c. Walking ability

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

   d. Normal work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

   e. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

   f. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

   g. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Patient initials: _____

PCS					
Everyone experiences painful situations at some point in their lives. Such experiences may include pelvic pain, headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures, or surgery. *We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain.* *Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.*					
	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
1. I worry all the time about whether the pain will end.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2. I feel I can't go on.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. It's terrible and I think it's never going to get any better.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4. It's awful and I feel that it overwhelms me.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. I feel I can't stand it anymore.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6. I become afraid that the pain will get worse.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7. I keep thinking of other painful events.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8. I anxiously want the pain to go away.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9. I can't seem to keep it out of my mind.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10. I keep thinking about how much it hurts.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
11. I keep thinking about how badly I want the pain to stop.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
12. There's nothing I can do to reduce the intensity of the pain.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
13. I wonder whether something serious may happen.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Patient initials: _____

General Social Constraints (GSC) Scale				
Sometimes, even when your friends and family members have good intentions, they may say or do things that upset you. Think about the PAST MONTH and indicate how often your friends or family members did the following things.				
	Never	Rarely	Sometimes	Often
1. Changed the subject when you tried to discuss your problems?	☐ 1	☐ 2	☐ 3	☐ 4
2. Seemed that they did not understand your situation?	☐ 1	☐ 2	☐ 3	☐ 4
3. Avoided you?	☐ 1	☐ 2	☐ 3	☐ 4
4. Minimized your problems?	☐ 1	☐ 2	☐ 3	☐ 4
5. Seemed to hide their feelings?	☐ 1	☐ 2	☐ 3	☐ 4
6. Acted uncomfortable when you talked about your problems?	☐ 1	☐ 2	☐ 3	☐ 4
7. Trivialized your problems?	☐ 1	☐ 2	☐ 3	☐ 4
8. Complained about their own problems when you wanted to share yours?	☐ 1	☐ 2	☐ 3	☐ 4
9. Acted cheerful around you to hide their true feelings and concerns?	☐ 1	☐ 2	☐ 3	☐ 4
10. Told you not to worry so much about your problems?	☐ 1	☐ 2	☐ 3	☐ 4
11. Told you to try not to think about your problems?	☐ 1	☐ 2	☐ 3	☐ 4
12. Given you the idea that they didn't want to hear about your problems?	☐ 1	☐ 2	☐ 3	☐ 4
13. Made you feel as though you had to keep your feelings about your problems to yourself, because they made them feel uncomfortable?	☐ 1	☐ 2	☐ 3	☐ 4
14. Made you feel as though you had to keep your feelings about your problems to yourself, because they made them upset?	☐ 1	☐ 2	☐ 3	☐ 4
15. Let you down by not showing you as much love and concern as you would have liked?	☐ 1	☐ 2	☐ 3	☐ 4