Female Pelvic Medicine & Reconstructive Surgery
Beth Israel Deaconess Medical Center (BIDMC)

Name: ____ Age: ____________________

Reason for visit/referral: ____

Are you referred for or interested in surgery? Yes _____ No ______ Maybe ________

Referring physician: _____________________________________ Specialty: _________________
Referring physician address: _____________________________________

Primary Care Physician: ______________________________________
PCP physician address: ______________________________________

Past Medical History
Do you currently have, or have you had in the past, any of the following conditions?

____ Glaucoma	____ Hepatitis/Liver Disease	____ Low back pain
____ Lung disease	____ Seizures/Epilepsy	____ Diabetes
____ Heart attack	____ Multiple Sclerosis	____ Autoimmune disease
____ High blood pressure	____ Stroke	____ Lupus
____ Congestive heart failure	____ Parkinson's disease	____ Thyroid disease
____ Blood clots	____ Spinal Bifida	____ Depression
____ Bleeding disorders	____ Trauma to spinal cord	____ Anxiety
____ Cancer	____ Brain injury	____ Fibromyalgia
____ Kidney stones	____ Disc herniation	____ Osteoporosis

What other medical problems (which are not listed above) do you suffer from?
____
____

Past Surgical History
Please list the surgeries you have had: Year

____ ________________
____ ________________
____ ________________
____ ________________
____ ________________
____ ________________
____ ________________

Past GYN History
Date of last period: ___________ Your Periods: ☐are regular ☐ or irregular
Date of last pap smear test: ____ / ____ / ____ Have you ever had an abnormal pap test?: ☐ YES ☐ NO

Past Obstetrical History
Total # pregnancies: _____ # of Vaginal Deliveries: _____ # of Cesarean Section: ______
# of Living Children: _____ # of Ectopics: ______ # of Abortions: ______
Birth weight of largest baby delivered vaginally: __________
Did you ever have a forceps-assisted vagina delivery? ☐ YES ☐ NO
Did you ever have a vacuum-assisted vaginal delivery? ☐ YES ☐ NO

Family History

Has anyone in your family had any of the following illnesses?

Condition	Relation (eg. father)	Condition	Relation (eg. father)
____ Heart attack	________________	____ Colon Cancer	________________
____ High blood pressure	________________	____ Uterine Cancer	________________
____ Stroke	________________	____ Ovarian cancer	________________
____ Blood clots	________________	____ Breast Cancer	________________
____ Bleeding disorders	________________		

What other medical problems run in the family? ____

Social History

Marital status: ☐single ☐married ☐living with partner ☐divorced ☐other:__________

Current or most recent job: ____

Do you smoke? ☐ YES ☐ NO Have you ever smoked? ☐ YES ☐ NO

How many cigarettes per day? ____________________ For how many years? ________________

How many alcoholic beverages do you drink per week? _______________________________________

Do you take illicit drugs? ☐ YES ☐ NO Which ones? _______________________

Have you ever been sexually abused? ☐ YES ☐ NO

Allergies

Medication Allergies: ____

Latex Allergic: YES NO Other Allergies: __________________________________

Medications

If your medications are not part of our electronic medical records system, please list all your current medications (include herbal and non-prescription medications):

Medication	Dose
________________________________	____
________________________________	____
________________________________	____
________________________________	____
________________________________	____
________________________________	____
________________________________	____
________________________________	____

Review of Systems

Do you have any of the following symptoms?

Constitutional
____ Fever

Eyes
____ Blurry vision
____ Glasses/contact lens

Ear, nose and throat
____ Hearing problems

Cardiovascular
____ Chest pain
____ Difficulty breathing on with activity
____ Leg swelling and/or feet
____ Heart murmurs
____ Heart palpitations

Respiratory
____ Shortness of breath
____ Chronic cough

Gastrointestinal
____ Constipation
____ Abdominal pain
____ Bloody stools
____ Frequent diarrhea

Genitourinary
____ Abnormal vaginal bleeding

Musculoskeletal
____ Muscle weakness
____ Low back pain

Neurological
____ Numbness
____ Headaches

Mental Health
____ Memory Loss

Endocrine
____ Hot flashes
____ Abnormal thirst

Hematologic/Lymphatic
____ Excessive bruising
____ Cuts that do not stop bleeding

If you have a problem with urination, prolapse, and/or fecal incontinence, please answer the following questions. Please circle the appropriate answer.

URINARY INCONTINENCE

1. Do you leak urine? Yes NO
2. If yes, how long have you leaked urine? ______Months / years
   The urine leakage is getting: Same Better Worse
3. If you do leak urine, how many times a day do you leak? _______
4. Do you leak urine with cough, sneeze, lifting, laugh, or exercise? Often Sometimes Rarely Never
5. How often, on average, do you urinate during the day?
   Every 0.5 hour 1hr 1.5 hrs 2 hrs 2.5 hrs 3 hrs or more
7. How often do you get up at night to void? 0 1 2 3 4 >=5
8. When you have an urge to void, do you leak urine before making it to the toilet?
   Often Sometimes Rarely Never
9. Do you receive little warning and suddenly find that you are losing urine beyond your control?
   Often Sometimes Rarely Never
10. Are you aware of when you have urine leakage? YES NO
11. Do you lose urine continuously? YES NO
12. Right after you have voided, do you have any further dribbling out of urine? YES NO
13. What kind of protection do you wear for leakage?
    None Pantyliner Mini-pad Maxi-pad Incontinence Pad (Eg: Poise, Depends)
14. How often do you change your pad per day? 1 2 3 4 >=5
15. What prior treatment(s) for urinary incontinence have you had?
    None Kegels Physical therapy Biofeedback Electrical Stimulation
    Urethral injections Surgery Interstim
    Medications: Oxybutynin Detrol Ditropan Oxytrol Gelnique Enablex Miragegron
    Vesicare Sanctura Imipramine Urecholine Toviaz Estrogen Other

URINARY SYMPTOMS

16. How often do you get bladder infections? Never < 1/year 1-2/year 3-4/year >= 5/year
17. Have you ever had kidney stones? YES NO
18. Have you ever had blood in the urine? YES NO
19. Do you have burning associated with voiding? YES NO
20. Do you have pain or pressure associated with voiding? YES NO
21. Do you feel like your bladder is empty after you have voided? YES NO
22. Do you have to strain to void? YES NO
23. Is your urine flow: normal intermittent hesitant slow
24. Do you need to push on your vagina, bladder, rectum to urinate or defecate? YES NO

PROLAPSE

25. Do you have pressure, or a feeling of a 'bulge' or tissue dropping in the vagina? YES NO
26. What prior treatment have you had for pelvic organ prolapse? None Pessary Surgery

GASTROINTESTINAL

27. Do you have problems with constipation? Often Sometimes Rarely Never
28. Do you have difficulty with defecation/bowel movements? Often Sometimes Rarely Never
29. Do you lose stool involuntarily? Often Sometimes Rarely Never

SEXUALITY

30. Are you sexually active? YES NO
31. Does your problem with urination and/or prolapse interfere with intercourse? YES NO
32. With intercourse, do you have any of the following? Pain Numbness Vaginal dryness Inability to orgasm

NAME ______________________ ______________

Are you referred for or interested in surgery? Yes _____ No ______ Maybe ________

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)

Do you experience, and, if so, how much are You bothered by.....	Not at all	Somewhat	Moderately	Quite a bit
Usually experience pressure in the lower abdomen?				
Usually experience heaviness or dullness in the pelvic area?				
Usually have a bulge or something falling out that you can see or feel in your vaginal area?				
Ever have to push on the vagina or around the rectum to have or complete a bowel				
Usually experience a feeling of incomplete bladder emptying?				
Ever have to push up on the bulge in the vaginal area with your fingers to start or complete urination?				

Pelvic Floor Impact Questionnaire

Instructions: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feeling. For each question place an X in the response that best describes how much you're activities, relationships, or feelings have been affected by your bladder, bowel, or vaginal symptoms or conditions over the last 3 months. Please make sure you mark an answer in all 3 columns for each question.

How do symptoms or conditions relate to the following ... Usually affect your	*Bladder or Urine*	*Bowel or Rectum*	*Vagina or Pelvis*
1. Ability to do household chores (cooking, housecleaning, laundry)?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
3. Entertainment activities such as going to a movie or concert?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
5. Participating in social activities outside your home>	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
6. Emotional health (nervousness, depression, etc)?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□Not at all □ Somewhat □Moderately □Quite a bit
7. Feeling frustrated?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit

Urinary Incontinence Assessment in Older Adults

UROGENITAL DISTRESS INVENTORY SHORT FORM (UDI-6)

Please answer each question by checking the best response. While answering these questions, please consider your symptoms over the last 3 months. We realize that you may not be having problems in some of these areas, but please fill out this form as completely as possible.

Do you experience, and if so how much are you bothered by…	Not at all	Slightly	Moderately	Greatly
Frequent urination	0	1	2	3
Leakage related to feeling or 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

INCONTINENCE IMPACT QUESTIONNAIRE-SHORT FORM (IIQ-7)

Some people find that accidental urine loss may affect their activities, relationships, and feelings. The questions below refer to areas in your life that may have been influence or changed by your problem. For each question, circle the response that best describes how-much your activities, relationships, and feelings are being affected by urine leakage.

Has urine leakage affected your…	Not at all	Slightly	Moderately	Greatly
1. Ability to do household chores (cooking, housecleaning, laundry)?	0	1	2	3
2. Physical recreation such as walking, swimming, or other exercise?	0	1	2	3
3. Entertainment activities (movies, concerts, etc.)?	0	1	2	3
4. Ability to travel by car or bus more than 30 minutes from home	0	1	2	3
5. Participation in social activities outside your home?	0	1	2	3
6. Emotional health (nervousness, depression, etc.)?	0	1	2	3
7.Feeling frustrated	0	1	2	3

Items 1 and 2 = physical activity; Items 3 and 4 = travel
Item 5 = social/relationships; Items 6 and 7 = emotional health
Scoring: Item responses are assigned values of 0 for "not at all," 1 for "slightly," 2 for "moderately," and 3 for "greatly." The average score of items responded to is calculated. The average, which ranges from 0 to 3, is multiplied by 33 1/3 to put scores on a scale of O to I00.

Reference: Uebersax, J.S., Wyman, J.F., Shumaker, SA., McClish, D.K.,Fantl, JA., & the Continence Prograrn for Women Research Group. (1995). Short forms to assess life quality and symptom distress for urinary incontinence in women: the Incontinence Impact Questionnaire and the Urogenital Distress Inventory. *Neurology and*