UFHealth
UNIVERSITY OF FLORIDA HEALTH

Name: _____

Age: _____ **Date of Birth:** _____

Today's Date: _____

Female Pelvic Medicine and Reconstructive Surgery Health Questionnaire

Review of Symptoms: Please check all that apply to you recently

GENERAL	HEENT	ENDOCRINE
O Fatigue	O Hearing loss	O Cold intolerance
O Night sweats	O Heavy snoring	O Excessive thirst
O Weight gain	O Nose Bleeds	O Heat intolerance
O Weight loss	O Ringing in the ears	O Hot flashes
EYES	**GI**	**UROGYNECOLOGIC**
O Blurry Vision	O Abdominal pain	O Daytime Wetting
O Cataracts	O Black colored stools	O Dribble after urination
O Excessive dryness	O Bloating	O Frequent urination
O Loss of vision	O Blood in stool	O Blood in urine
ALLERGIC/IMMUNE	O Accidental bowel leakage	O Incomplete emptying
O Frequent infections	O Constipation/Straining	O Leak with cough/sneeze
O Seasonal allergies	O Diarrhea	O Leak with exercise
O Severe allergic reaction	O Difficulty swallowing	O Leak with intercourse/orgasm
NEUROLOGICAL	O Heartburn/Indigestion	O Leak with position change
O Memory loss	O Nausea	O Leak with urgency
O Numbness	O Need finger/Hand to empty	O Loss of urine during sleep
O Seizures	O Poor appetite	O Low sexual desire
O Severe Headaches	O Vomiting	O Need to push on/in vagina to urinate
MUSCULOSKELETAL	**CARDIOVASCULAR**	O Painful urination
O Back pain	O Chest pressure/pain	O Partner sexual problems
O Buttock pain	O Fainting	O Unconscious leakage
O Joint pain	O Leg swelling	O Urgency to urinate
O Leg pain	O Palpitations	O Vaginal discharge
O Weakness	**INTEGUMENTARY**	O Vaginal dryness
LUNGS	O Rash	O Vaginal bulge/prolapse
O Asthma	O Mole changes	O Vulvar/vaginal pain
O Cough	O Growths	O Weak urine stream
O Shortness of Breath	O Nail changes	
O Wheezing	**BLOOD**	
PSYCHOSOCIAL	O Easy bruising	
O Anxiety/Nervousness	O Excessive bruising	
O Depression/Sadness	O Swollen lymph nodes	
O Insomnia		

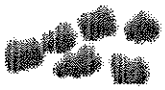
Urogynecologic Symptoms:

1) Do you feel like you have a bulge or a ball coming out of your vagina? Yes No
2) How often do you go to the bathroom to empty your bladder (pee) on an average day?
   1-3 4-6 8-10 10-12 12-14 Other: _____
3) How often does the need to empty your bladder (pee) wake you up on an average night?
   0 1-2 2-3 3-4 4-5 Other: _____
4) How much fluids do you drink in an average day:
   a. Water _____ ounces, glasses, bottles
   b. Coffee _____ ounces, mug, paper cup
   c. Tea _____ ounces, mug, cup
   d. Sodas _____ ounces, glasses, bottles
   e. Carbonated water _____ ounces, glasses, bottles,
   f. Lemonade _____ ounces, glasses
   g. Orange Juice _____ ounces, glasses
   h. Other juices _____ ounces, glasses
   i. Sports drinks _____ ounces
   j. Other _____
5) Have you tried any of the following medications for your bladder symptoms?
   Oxybutynin/Ditropan Darifenacin/Enablex
   Solifenacin/Vesicare Mirabegron/Myrbetriq
   Trospium/Sanctura Darifenacin/Enablex
   Tolterodine/Detrol Other: _____
6) Do you leak (lose) urine when you feel urgency and you cannot make it to the bathroom quickly enough?
   a. If yes, Please estimate how often do you leak (lose) urine when you cannot get to the bathroom quickly enough: ____ times per day ____ times per week
7) Do you leak (lose) urine with any of the following activities (circle all that apply)?
   Laughing Sneezing Jumping Walking Running
   a. If yes, how often do you leak with these activities? _____ per day _____ per week
8) Do you leak urine and not realize it until you look at your underwear or pad? Yes No
9) Do you ever wake up at night wet with urine in your pad or underwear or bed? Yes No
10) How many pads do you use per day? _____ If yes, what types of pads do you use? _____
11) Do you feel like you empty your bladder? Yes No
12) Do you frequently experience burning with urination? Yes No
13) Have you ever seen blood in your urine? Yes No
14) Have you ever had 3 or more urinary tract infections (UTI) in 12 months? Yes No
15) How many urinary tract infections (UTI, cystitis) have you had in the past 12 months? _____
16) Number of bowel movements (poop) _____ per day _____per week

17) Do you have to strain for a bowel movement? Yes No

If yes, how often do you strain? _____

18) What do your bowel movements look like (circle all that apply)?

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on the surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. **Entirely Liquid**

19) Do you experience accidental bowel (stool) leakage? Yes No

20) Do you have to push on your vagina or rectum to have a bowel movement? Yes No

21) Do you experience vaginal dryness? Yes No

22) Are you sexually active? Yes No

23) Do you have pain during sex? Yes No Not applicable -Not sexually active

24) Any history of abnormal PAPs? Yes No

25) When was your last PAP smear? _____

26) Do you have a family history of breast cancer? Yes No

27) Do you have a family history of ovarian cancer? Yes No

28) Do you have a family history of uterine cancer? Yes No

29) Do you have a family history of colon cancer? Yes No

30) Do you have family history of pancreatic cancer? Yes No

Please proceed to the next page. Thanks!

Reason for visit:

How long have you had these problems? _____

Have you had treatments for this in the past? ☐ Yes ☐ No

If yes, what treatments? _____

Current Medications (PROVIDER: Please compare medication list below to the patient's electronic medical record): Please list all medications you take, including over-the-counter and herbal supplements

Medication and Dose:	Medication and Dose:

Allergies: Please list all medications you are allergic to and the side effect

Medical History: Please check if you have or have had any of the following:

☐	Anemia	☐	Fibromyalgia	☐	Multiple Sclerosis
☐	Angina / Chest Pain	☐	Gallbladder Problems	☐	Neurologic Problems
☐	Anxiety	☐	Gastroesophageal Reflux Disease (GERD)	☐	Osteoporosis
☐	Arthritis	☐	Glaucoma	☐	Refusal of Blood Products
☐	Asthma	☐	Heart Attack/MI	☐	Renal Disease
☐	Back Injury / Pain	☐	Heart Arrhythmia	☐	Seizures / Fainting / Strokes
☐	Bleeding Disorder	☐	High Blood Pressure (Hypertension)	☐	Rheumatoid Arthritis
☐	Taking Blood Thinners	☐	Hemorrhoids	☐	Sickle Cell Anemia
☐	Blood Clots in Lungs	☐	Hepatitis	☐	Sleep Apnea
☐	Blood Clots in Veins	☐	High Cholesterol	☐	Strokes
☐	Blood Transfusion	☐	Inflammatory Bowel Disease	☐	Stomach / Gastric Ulcers
☐	Chronic Bronchitis	☐	Irritable Bowel Syndrome	☐	Thyroid Problems (High / Low)
☐	Chronic Pain	☐	Kidney Infections		
☐	Chronic Obstructive Pulmonary Disease (COPD)	☐	Kidney Stones	☐	Urinary Tract Infections
☐	Congestive Heart Failure (CHF)	☐	Leukemia / Lymphoma	☐	Breast Cancer
☐	Coronary Artery Disease	☐	Liver Cirrhosis/Disease	☐	Colon or Rectal Cancer
☐	Depression	☐	Lupus	☐	Uterine Cancer
☐	Diabetes	☐	Mental Illness	☐	Ovarian Cancer
☐	Diverticulitis	☐	Memory Loss	☐	Other Cancer? _____
☐	Emphysema	☐	Migraines		

Other medical issues: _____

Surgical History: Please check all that apply to you

	Date		Date		Date
☐ Abdominal Aortic Aneurysm	_____	☐ Cesarean Section	_____	☐ Knee Surgery	_____
☐ Appendectomy	_____	☐ Cosmetic Surgery	_____	☐ Lung Surgery	_____
☐ Back Surgery	_____	☐ Ears / Nose / Throat Surgery	_____	☐ Ovary Surgery / Removal	_____
☐ Bladder Surgery	_____	☐ Eye Surgery	_____	☐ Shoulder Surgery	_____
☐ Bowel Surgery	_____	☐ Gallbladder	_____	☐ Spleen Surgery	_____
☐ Brain Surgery	_____	☐ Heart Surgery	_____	☐ Tubal Ligation	_____
☐ Breast Lumpectomy	_____	☐ Hernia Repair	_____	☐ Stomach Surgery	_____
☐ Breast Mastectomy	_____	☐ Hip Surgery	_____	☐ Tonsillectomy	_____
☐ Cardiac Bypass/Stents	_____	☐ Hysterectomy	_____	☐ Vaginal Prolapse Repair	_____
☐ Cardiac Catheterization	_____	☐ Kidney Surgery	_____	☐ Wisdom Teeth Extraction	_____

Other Surgeries: _____

Have you ever had:	Yes	Unknown	No	Was the incision Abdominal, Vaginal or Laparoscopic?
Hysterectomy?	☐	☐	☐	_____
Removal of your ovaries?	☐	☐	☐	_____
Bladder surgery?	☐	☐	☐	_____
Rectal surgery?	☐	☐	☐	_____
Surgery for prolapse?	☐	☐	☐	_____
Mesh/graft placed?	☐	☐	☐	_____

Gynecologic History:

1. First day of last menstrual period: _____
2. Type of contraception: _____
3. If you have stopped menstruating, at what age did you stop? _____
4. Have you had bleeding or spotting since your period stopped? ☐ Yes ☐ No
5. Have you ever been on hormone therapy after menopause (estrogen/progesterone)? ☐ Yes ☐ No
6. Do you have hot flashes, night sweats, or vaginal dryness? ☐ ☐ No Which? _____
7. Last Mammogram: _____
8. Last Pap Smear: _____
9. Have you ever had an abnormal Pap smears? ☐ Yes ☐ No If yes, when? _____

Any personal History of: Check all that apply

☐ Sexually transmitted diseases ☐ Endometriosis ☐ Fibroids ☐ Heavy Menstrual Bleeding

Sexual History:

1. Have you had intercourse in the last year?
2. If no, why? (no partner, painful intercourse, vaginal dryness, partner factor, or due to vaginal bulge or incontinence, no sex drive) _____
3. Do you experience pain or discomfort with sexual intercourse? ☐ Yes ☐ No

Obstetrical History:

1. How many times have you been pregnant?
2. How many children did you deliver? Vaginal?_____ Cesarean Delivery? _____
3. How big was your biggest baby? _____ pounds
4. Were forceps used? ☐ Yes ☐ No
5. Did you have any episiotomies? ☐ Yes ☐ No Any tears into or through the rectum? ☐ Yes ☐ No
6. How many miscarriages or abortions have you had? _____
7. List any problems with deliveries: _____

Personal/Social History:

	Yes	No	
Smoking	☐	☐	☐ Quit Packs per day:_____ Years:_____ Date Quit: _____
Caffeine	☐	☐	☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drinks Glasses per day_____
Alcohol	☐	☐	Drinks per day:_____ Drinks per week: _____
Recreational Drugs	☐	☐	Type_____ Uses per week: _____
Mobility Issues	☐	☐	☐ Cane ☐ Walker ☐ Wheelchair Other: _____
Violence at Home	☐	☐	
Marital Status	☐	☐	☐ Married ☐ Single ☐ Divorced ☐ Widowed
Living Situation	☐	☐	☐ Lives Alone ☐ Lives with Partner/Family ☐ Assisted Living

Occupation: _____